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ABSTRACT

To increase awareness of ideas that have potential for solving nursing problems, the papers in these proceedings review research findings, describe the application of problem-solving techniques, and underscore the joint responsibility of service and education for testing innovations in better patient care. The proceedings contain: (1) "Don't Just Sit There--Do Something," by Florence Downs, which expresses a concern for developing meaningful content and testable theory at the center of research efforts in nursing; (2) "Understanding Attitudes and Conditions That Determine Nurses' Environments for Research," by Maxine Loomis, which discusses the impact of the Conduct and Utilization of Research in Nursing project, a 5-year research development effort sponsored by the Michigan Nurses' Association; (3) "Why Aren't the Advances of Nursing Research Being Implemented at Bedside?" by Judith Floyd, Karin Kirchhoff, Phyllis Kritek, and Susan Riesch, which offers criteria for the evaluation of research findings among clinicians; (4) caucus group reports on common problems, current work that has potential for solving patient care problems, and research-related objectives; and (5) brief descriptions of 45 ideas and innovations to improve nursing practice. (RO)

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INNOVATIONS AND INVENTIONS:

Ideas for Improving Nursing Service and Nursing Education

Midwest Alliance in Nursing
Spring Meeting
April 1982

JC 860 409

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INNOVATIONS AND INVENTIONS:
IDEAS FOR IMPROVING NURSING SERVICE AND NURSING EDUCATION

Proceedings of the Spring Conference
April 1-2, 1982
Pfister Hotel
Milwaukee, WI

Edited by

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INNOVATIONS AND INVENTIONS:
Ideas for Improving Nursing Service and Nursing Education

Preface

Utilization of research findings as a scientific basis for nursing has been notably deficient in both teaching and clinical practice. This deficiency has hampered the general acceptance of nursing as a science, and continues to weaken nursing's credibility among the other health sciences. In the past, it almost seems as though the parts of nursing that best lent themselves to objective measurement, such as respiratory therapy, were one by one taken away from nursing leaving behind only those highly variable and intuitive patient care activities with nursing. The consequences for nursing have been a lack of a sense of discovery; and clinical decision-making for patient care that lacks a sound data base.

Furthermore, women historically have been only very rarely credited with invention or innovation. For these reasons it was determined that MAIN should sponsor a regionwide conference to examine these issues. Innovations and Inventions - Ideas for improving nursing service and nursing education was intended to increase awareness of ideas that have potential for solving nursing problems in service or education. Application of problem-solving ideas and resources for generating problem solutions were also topics included in this program. The joint responsibility of service and education for testing innovations for better patient care was an additional objective.

The contemporary nurse researchers invited to speak included, Nursing Research's editor, Florence Downs, RN, EdD, FAAN, who shared her concern for developing meaningful content and testable theory at the center of research effort. Utilization or adoption of theory without sufficient validation is a prime concern in a field developing so rapidly as nursing.

Maxine Loomis, RN, PhD, discussed the impact of the Conduct and Utilization of Research in Nursing (CURN) project, a five-year research development effort sponsored by the Michigan Nurses' Association. The CURN project addressed problems of utilization of existing research findings directly, and focused on research readily transferable to practice. This endeavor, now completed and published by Grune & Stratton, has brought about many needed changes in the process of application of nursing research.

The panelists each represented a different area of nursing specialization, but all were involved in implementation and development of research with clinical emphasis. Their discussions shed light on the progress they observed, and at the same time, they agreed that knowing how to test and evaluate research findings was often lacking among clinicians. They offer criteria for such evaluation.

Finally, the caucus group recommendations also included in this proceedings, helped to identify some insightful diagnoses and practical goals with regard to MAIN's future role in regional research development. These timely views will give Midwestern and other nurses a better understanding of the importance and utility of well-grounded, validated, and clinically relevant research findings.

Patricia Diamond, Chair, Midwest Alliance in Nursing	Barbara B. Minckley, Executive Director

Acknowledgements

MAIN wishes to thank its many members and participants who planned or took part in the program reported in these proceedings. Innovations could be said to be MAIN's primary mode of operation during its formative years. If so, a large measure of creativity has certainly been provided by MAIN's Program Committee comprised, in 1981-82 of, Annette Scheffel, Assistant Professor, University of Iowa College of Nursing, Iowa City, IA; Carolyn Littlejohn, Director of Education, Visiting Nurse Association, Milwaukee, WI; Mary Morris, Administrator for Nursing Services, Henry Ford Hospital, Detroit, MI; and Mary Lou Taylor, Director, Nursing Program, Johnson County Community College, Overland Parks, KS.

The editors are indebted to Vicki Johnson, Administrative Secretary, whose virtuosity and innovation at the keyboard of the word processor brings MAIN's proceedings into published form. And finally the funding support of the W. K. Kellogg Foundation is also gratefully acknowledged.

The editors

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Biographical Sketches of the Authors

Florence S. Downs, EdD, FAAN,: Professor, Associate Dean and Director of Graduate Studies, University of Pennsylvania School of Nursing; editor, Nursing Research. She has held leadership roles in ANA, NLN, APHA, Sigma Theta Tau, and Pi Lambda Theta. Adding to a long list of publications, she writes editorials for Nursing Research. Businesses, charitable organizations, and universities seek her expertise as a consultant. Several publishing companies rely on her as publications reviewer. She has presented many papers, several of which relate nursing research to nursing practice. Dr. Downs' honors include the Distinguished Alumni Award from New York University; being a Visiting Scholar at the University of Toronto; receiving a MA, Honoris Causa, from the University of Pennsylvania; and being listed in Outstanding Educators in America: Men and Women of Science.

Maxine E. Loomis, PhD, FAAN: Professor and Director, Doctoral Program, University of Illinois, College of Nursing, formerly Professor of Nursing, Psychiatric/Mental Health Department, University of Michigan School of Nursing (where she recently received the Research Publications Award); Program Director of the (Conduct and Utilization of Research in Nursing (CURN) project. Dr. Loomis' professional roles extend to being a clinical teaching member of the International Transactional Analysis Association, and a Certified Specialist of PsychiatricMental Health Nursing of the American Nurses' Association. Her research activities include "The Development of a Behavior Rating Scale to be Used with Psychiatric Nursing Personnel," and "Group Contingent Reinforcement of Chronic Psychiatric Patients." She guides graduate students by participating on student committees, and serves as a consultant to groups and organizations on group process and clinical research. She has published numerous journal articles and books, including "Interpersonal Change: A Behavioral Approach to Nursing Practice, (New York: McGraw Hill, 1974); and Group Process for Nurses, (St. Louis: C.V. Mosby, 1979). Dr. Loomis is active in Sigma Theta Tau, ANA, and serves on the Research and Publication Committees of New Directions in Education and Psychotherapy.

Susan K. Riesch, DNSc.: Associate Professor of Nursing, Director of the University of Wisconsin-Milwaukee Nursing Center; Nurse Researcher at Mt. Sinai Medical Center. Dr. Riesch's research interests have resulted in the successful completion of several projects, with the new information communicated through publications and papers presented at professional meetings. Recent research activities include "The Nursing Center: Wellness for the Individual, Family, and Community"; "A Model to Study the Effectiveness of a Nursing Intervention Upon Maternal-Infant Social Interaction"; and Occupational Commitment, Role Conflict, and the Quality of Maternal-Infant Interaction. Recent papers are "The Impact of a Nursing Intervention Upon Maternal-Infant Interaction," (Western Nurse Researcher Conference, Tucson, Arizona, 1980), and "Combining Motherhood and Profession," (Woman to Woman Conference, Milwaukee, Wisconsin, 1980). A partial mention of awards and honors includes: Sigma Theta Tau, Outstanding Young Women of America-1980, and recipient of a predoctoral fellowship in September 1978 authorized by the National Research Service Awards, DHEW, Public Health Service, Health Resource Administration.

Judith A. Floyd, RN, MS: Nurse Researcher in Detroit working with the Lafayette Clinic and the Center for Health Research at Wayne State University, facilitating joint research efforts between the two organizations. At Lafayette she develops and implements clinical nursing research projects, as well as evaluates patients' satisfaction with services provided. As a research assistant at the Center, Ms. Floyd assists the College of Nursing research faculty with computerized data analysis. She is completing work for a Ph.D., on the topic "Hospitalization, Sleep-Wake Patterns, and Mood States in a Psychiatric Population." Ms. Floyd is an active member of professional organizations including Sigma Theta Tau, ANA, and the ANA Council of Nurse Researchers. Her most recent publications are "Effect of Hospitalization on Sleep and Mood Rhythms Among the Depressed," in the Proceedings of the First Effective Disorders National Nursing Conference (Iowa City: The University of Iowa Press, 1982), and "The Rhythm Perspective: Relation to Nursing Models", *Nursing Models: Application for Psychiatric Mental Health Nursing* (Bowie, MD: Brady Company, 1982).

Phyllis B. Kritek, PhD: Associate Professor of Nursing, Director of the Center for Nursing Research and Evaluation at the University of Wisconsin-Milwaukee School of Nursing. Her extensive experience as a consultant includes implementing nursing diagnoses in acute care settings, facilitating nursing research in the clinical setting, and advising on research to faculty and graduate students at the University of Wisconsin-Milwaukee School of Nursing. Dr. Kritek serves on the editorial board of *Advances in Nursing Sciences*. Her most recent publications are *Developing a Research Climate in a University School of Nursing* (Milwaukee: University of Wisconsin-Milwaukee School of Nursing, 1981); "Patient Power and Powerlessness" (Supervisor Nurse, 1981); and "The Generation and Classification of Nursing Diagnoses: Toward a Theory of Nursing," in Classification of Nursing Diagnoses," Proceedings of the Third and Fourth National Conferences (New York: McGraw-Hill, 1981). By presenting papers, making speeches, and conducting workshops, Dr. Kritek extensively communicates nursing issues. She helped develop the videotape instructional program "Home Delivery: One Family's Experiences"; and as a faculty coordinator developed, "Tools for Discussion" for psychiatric nursing. She actively participates in ANA, Missouri Nurses' Association, Midwest Nursing Research Society, and Sigma Theta Tau.

Karin Kirchhoff, PhD, RN: Clinical Nursing Research Coordinator, Assistant Professor of General Nursing at the University of Illinois Hospital and Clinics, College of Nursing, Chicago, Illinois. Dr. Kirchhoff was Principal Investigator of the research project "An Evaluation of the Hollister Fecal Incontinence Device," 1980-81; is a Consultant, Ad Hoc Committee for Needs Survey, Chicago District Nurses' Association; and participated in the Division of Nursing, HEW, meeting, "Future Directions for Nursing Research: 1980-1990," June 1979. She reviews manuscripts for Heart & Lung and Research in Nursing & Health. Her publications include "A Diffusion Survey of Coronary Precaution," soon to be published in Nursing Research; "A Strategy for Surveying Nursing Practice in Institutional Settings," (Research in Nursing & Health, 1981; "Compilation of Research Abstracts for Critical-Care Nurses-1979" (2nd ed.), (Irvine, CA: American Association of Critical Care Nurses, 1981). She is an active member of ANA, NLN, Sigma Theta Tau, and the Midwest Nursing Research Society.

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DON'T JUST SIT THERE - DO SOMETHING

Florence Downs, EdD, FAAN

I consider myself very fortunate. My experience with development of research in nursing spans a period of about 17 years. I had no plan; I simply stumbled into the whole thing. Certainly, I never thought my career would be built around research.

I was fortunate enough to be able to attend almost all of the first American Nurses' Association (ANA) conferences on research as well as the early theory conferences. These activities set the stage for the establishment of the ANA Commission on Nursing Research and subsequently, the Council of Nurse Researchers.

Thus, the perspectives I bring to this group are colored by my interpretation of what I believe I have seen happen. Certainly, my experience as editor of Nursing Research has added to the strengths of my opinions and convictions.

First of all, I would like to say that nurses are far more aggressive than for which they give themselves credit. True, there are some weak sisters among us, but nurses who set out to turn things around eventually do, if their strategies make any sense. If there is a problem, it is that we emphasize everything has to be done right, and preferably, completed yesterday.

Other professional groups have had the advantage of slow maturation in university settings to season their methodologies and disciplines, and gain them various degrees of respectability on campus. Even sociology, which certainly has no venerable position as a discipline, is at home in the university, and feels quite competent to make statements about nursing as an emerging profession.

The belief in the need for expediency and doing things right has taken us a long way quickly. The general tendency has been to focus on structure first and content second. However, some of this activity needs to be reexamined or we will wind up discovering the nursing profession is well-polished, but lacking in content. To oversimplify without turning the subject into a diatribe, let's look at some examples of what has happened.

We needed curriculum reform, so we turned to the field of education and borrowed threads and strands, behavioral objectives, taxonomies, and conceptual frameworks.

Many of these strategies were certainly useful. Faculty, however, sometimes became so obsessed with all of this that it took years to build content into an appropriate curriculum. For example, it still seems unworthy to consider that baccalaureate graduates may matriculate into a graduate program from a school with a conceptual framework that does not articulate with the one from which they graduated. Obviously, there is a hidden assumption that some common content is present in undergraduate programs upon which graduate content can be built, regardless of the nature of the conceptual framework.

Consider the history of our research endeavors. There was a general consensus among academic leaders, at least 20 years ago, that research was the foundation of professional knowledge and strengthened practice. We put research courses into graduate education and started to develop doctoral programs. In fact, our doctoral programs have developed very quickly and continue to do so.

The first research investigations were certainly less than impressive, largely because they were methodologically outrageous. Nurses worked diligently to correct all that. The problem is that in the course of all this effort, we have failed to stress the substance of the content. I cannot tell you how many manuscripts I have received that are totally devoid of logic or substance. They are, however, frequently methodologically impeccable.

Statistics though, are definitely "in." So much so that I am considering having a medal struck for the largest number of analyses found in any given piece of work. To date, the record is 382 correlations and 52 F tests for a single report. I realize computers are great tools, but little is accomplished by trying to kill a fly with a cannon.

Some manuscripts submitted to Nursing Research appear to be made up entirely of numbers rather than words. Of course, when so many analyses are done the meaning is lost because they are not guided by a theoretical or thoughtful framework. The author is then left with a mass of numbers and an insufficient way to explain the data.

Years ago I had a statistics professor who said it was possible to find a significant correlation between any two variables if you tried hard enough; for example, the hairs on a man's head could be made to correlate with the number of telephone poles in Iowa. Some of you may wish to test this for yourself.

A medal also should be designed for the author who produces the greatest number of tables and the most complicated schematic diagrams. With regard to schematics, it seems the emphasis on deriving conceptual systems and paradigms has led us again to forget the content, in this case testable theory--a necessary component of all research.

Paradigms in other disciplines grow out of concerted efforts that establish certain pieces of knowledge as having some logical stature within the discipline. Attempts to refute paradigms are difficult, particularly since they become established as givens. In actuality, there are probably fewer pieces of information that should be afforded this status than most scientists would admit.

Williamson (1980), in discussing the presence of scientific knowledge that could be used for assessing quality assurance, produced some interesting statistics. Literature reviews revealed that only 50 percent of the reported work in the hard sciences of chemistry and physics was usuable; 73 percent of the reports in 10 leading journals, such as the New England Journal of Medicine and the Journal of the American Medical Association, were of questionable validity. Indeed, studies done at Yale revealed that the proportion of scientifically supportable studies was shockingly low. I do not know what might be said about nursing literature. It is important to stress here, however, that publication in scientific literature makes work available to colleagues so they may evaluate, replicate, and refine--not necessarily apply. If these important steps are bypassed, they're may be cause for some real concern at a later date.

An example, that makes more than one maternal child nursing expert very uneasy, is the wholesale adoption and application of "bonding theory" without the necessary empirical validation to warrant it. Bonding theory has taken nursing literally by storm, and there is danger some real damage may result. The theory, and it is only a theory, was generated from a piece of research in Guatemala.

On that rather flimsy evidence, nurses have taken the theories of bonding and maternal attachment and applied them wholesale. They have seldom questioned whether the theory should be tested before adoption, or whether the research source from which it came should be evaluated. Lately, child guidance clinics have found parents who say, "I guess the whole problem is that I just didn't bond right." Nursing consumers should, therefore, use caution in assessing early results and be even more cautious in their application.

Replication is important and following one line of research until some reasonable definitive conclusions are reached is needed. Several examples follow.

STUDIES OF PREMATURE INFANTS

More than 20 years have elasped since the first research was done to determine the effect of modifying the early environment of premature infants. These efforts have been based on the notion that prematures have a high risk of later developing difficulties, not only due to biological problems, but also because their early postnatal environment lacks suitable variability. Neurophysiological studies tend to support this point of view. The actual monotony of the environment of a premature, enclosed in an isolette seems, or at least seemed, to make common sense when the first studies were initiated.

Hasselmeyer (1964) was among the first to use the rationale as the basis for providing what was then considered to be extra-early handling of prematures. Other studies followed that employed various techniques designed to enhance the environmental surroundings of the premature while still in an isolette.

Neal (1968) devised a hammock-type apparatus. It provided a periodic rhythmic swinging motion which she believed approximated the vestibular stimulation present during uterine life. When the infants involved in the experimental procedures were found to have a higher developmental status than those in the control group, Neal concluded that, indeed, the theoretical rationale was correct and the intervention was important to use as a clinical mode.

Katz (1971), a research assistant to Neal, believed the difference in performance was not due to the rocking motion, but rather to the novelty introduced into the mono tonous auditory environment by the sound of the motor that periodically operated the hammock. She designed a two group study that allowed the experimental group to receive periodic auditory stimulation from a tape recording of the mother's voice while in an incubator. The control group received routine care. Again, the experimental group showed developmental gains over the control group. As a clinician, and given the foregoing results, what would you opt to do? Would you recommend prematures be rocked or receive a recording of the mother's voice?

Obviously, a large train of complicated physiological and anatomical processes occur between periodic auditory stimulation with a mother's voice and developmental superiority in an experimental group. What might these be?

Chapman (1978) believed the difference in development was related to attenuation of random movement often observed in immature infants. She believed these movements consumed considerable energy that could otherwise be used for growth. She used a three-group design in which the mother's voice was introduced to one group of infants and music to the second goup. The latter group was used to control for the possibility that it was the mother's voice, in particular, that produced the effects. The third group received routine nursery care.

Chapman looked for significant differences between the groups in gross motor activity. None were found. The group exposed to music, however, gained weight more quickly and was discharged earlier than the other two groups of infants. This resulted in considerable financial savings for all concerned, which certainly seemed to be a plus.

A follow-up study by Molloy (1975) of the same infants on discharge from the hospital, using the Rosenblith Scale (1961), and seven months later using the Bayley Scale of Infant Development (1969) showed no significant differences among the groups. Although all the groups were within normal limits at nine months, the control group had an edge on the performance ratings.

As a clinician what would you do with these kinds of contradictory findings? Chapman has spent the past five years as a Canadian research scholar working on the problem. She presented a preliminary report of her research at the meeting of the Council of Nurse Researchers in 1981.

"Recently," she reported, "it has been demonstrated that supplemental stimulation in the nurseries of university teaching hospitals has no discernable effect at discharge on the preterm infant beyond that of the usual standard of care."

By this she meant use of music and the taped voice of the mother had no effect. She continued, however, to look for a sleeper effect. Since the children were alike at discharge, she conducted a longitudinal study which included groups that received stimulation at home until age three. There were no significant differences on the Bayley Scale at nine months or at 18 months. At three years and four years, there were no IQ differences in social or behavioral outcomes as measured by the Vineland Social Maturity Scale (Doll, 1953).

In Chapman's paper, there were some interesting comparisons made between the premature babies and the standardized baby population. However, this should not be allowed to obscure the findings that not only did in- hospital stimulation fail to make a difference, but also stimulation programs over a period of three years failed to make a difference.

Perhaps one of the most important things that will come out of this series of longitudinal studies is that Chapman will have a cohort of premature infants that have been followed for five years-of-age. Comparisons of a standardized population with a premature infant population have been rare since there has been virtually no follow-up done over such a long period of time. Also, the attrition from her sample has been remarkably low for this kind of study.

STUDIES OF PRE-OPERATIVE TEACHING

The next topical example is something that I know is dear to you -- pre-operative teaching. Everyone believes or wants to believe that such instruction can make a difference in post-operative outcomes. More energy probably has been directed toward the study of pre-operative teaching than toward just about any other area of nursing practice.

A variety of pre-operative approaches have been tried, including variations in the characteristics of the messages given and simple performance of respiratory maneuvers. Dependent variables used to measure these approaches have been extremely diverse and include all levels of conceptual abstraction ranging from anxiety, stress, patient welfare, vital capacity, and hospital days spent, to the amount of pain medication taken.

The proliferation of studies has shed little light on the issues. Investigators have continued to turn up contradictory conclusions that should be evident to even the most unsophisticated reader. Lindeman and Van Aernam (1971) reported positive results related to "stir-up" routines and preoperative teaching. These results failed to be replicated by Archuleta, et al (1977) in a large study supported by Western Interstate Commission for Higher Education in 1977. King and Tarsitano (1982) claim to have replicated the results of the Lindeman and Van Aernam study, but found no difference in length of hospital stay.

Few studies have attempted to verify whether patients actually perform exercises they have been taught, or whether they perform them correctly. In other words, the missing links between pre-operative instruction and postoperative outcomes never have been carefully viewed. As with the premature studies, there has to be something between instructing a patient regarding exercises and producing results, be it positive or negative. It just could be practice.

Ziemer tested some of these notions in an attempt to replicate Jean Johnson's work on pre-operative models of information giving. Ziemer checked whether patients performed the recommended coping strategies. A sizeable group did not remember receiving the instructions at all from any source. Even when exercises were recalled, they were practiced on an erratic basis. There were no differences in complications between patients who practiced the coping measures and those who did not.

Patients who practiced some of the exercises actually used more pain medication than those who did not practice the exercises. Intuitively, this makes sense because these patients were already in pain and the recommended exercises likely caused exacerbation of their pain. Further, patients were not reminded or helped by staff to carry out the prescribed procedures.

The above findings are in agreement with the findings of Risser, et al (1980) who found a high degree of variability in patients' self reports of post-operative exercise performance. Carrieri (1975) also reported that patients in the immediate post operative period may need psychological and physiological support from the health care team to perform the necessary exercises, particularly when pain may act as a negative reinforcer.

What can be said about all of this? If anything, we should pursue the matter further, to gain a better grasp of what is happening during the pre- and post-operative period. If procedures taught pre-operatively are important, why aren't they followed up by staff post-operatively? A bit of descriptive research could go a long way.

Furthermore, given all the other things that go on during the pre-operative and post-operative period, I am not sure that instructions should be expected to influence any of the variables being measured. In fact, it is not uncommon to meet discharged patients from many areas, especially new mothers, who apparently never received any instructions.

It is difficult to believe there are that many who have never received instructions at all.

I believe there is something here that has to do with timing and the way we are going about instruction that is an influential factor. No doubt some persons will think this would be a calamity and say, "Nurses have to be able to show that what nurses do makes a difference, otherwise no one is going to pay us to do it. How are we ever going to affect clinical practice if we spend so much time on something that produces little of importance?" This is not the way to look at the situation, as far as I am concerned. The moment is at hand when we cannot just sit there -- we have to do something.

I have been told that everyone knows pre-operative teaching is an established practice, and that it is unethical not to provide it. In fact, Ziemer met with a fair amount of resistance. The nursing staff told her it was "old hat," something everyone knew and there was no need to re-invent the wheel. In addition, the staff insisted that standardized pre-operative teaching existed on a routine basis and was carried out regularly. There was no indication of this, however, during the course of the study. A number of people may have been giving pre-operative instruction but it did not appear to be standardized.

It seems that if all of this is correct, then we should find a way to provide pre-operative instruction that is remembered and practiced. Also, it is time for someone to publish a thorough and critical review of the literature. Indeed, what is needed is an identification of the current state of the art that will indicate gaps in knowledge, avenues that look to be absolutely fruitless, and identify what looks as if it might yield something of importance.

By way of reassurance, there is a considerable lag in time between a breakthrough in information and the application of the information. In the social sciences when a major piece of information is uncovered it is apt to be 15 years before application takes place. I would hardly claim to be one who had produced anything as significant as a breakthrough in science, and I doubt if most of you would. Nonetheless, a personal experience serves as a case in point.

In 1975, I had a local jeweler develop an instrument to measure gross motor activity. Basically, it was a small self-winding calendar watch, altered so that rather than winding the watch, the force of movement drove the hands around the face to measure activity in minutes, hours, and days.

I had read an account in literature of what these actometers looked like, but the investigators refused to give me one of the instruments for inspection. I took the literature I had to a local jeweler, Mario Marcel, and explained what I wanted to do, and how the actometer would be applied to the study of premature infants.

He proceeded to break a number of expensive watches in an attempt to design the instrument. He finally noticed that at the bottom of one of the articles written about the actometers was the name of the original jeweler in Illinois who had developed them. Mario telephone him. The man, who at that time was retired, told Mario that only Omega watches would work because they had a special kind of gear in them. At that point, Mario bought some Omega watches and proceeded to make actometers, which are fantastically accurate and durable.

Mario undertook all this work at no charge to me. The only cost was the wholesale price he paid for obtaining the Omega watches. The reason he did all of this work was for the little premature babies and the idea that he might be able to influence their lives and help some of them live.

On completion of some of the premature studies, we took photographs of some of the infants wearing the actometers. I want you to know that Mario cried when I gave him the photographs, because it was so important to him to have participated in this kind of human activity.

Early in 1977, Fitzpatrick and I published a graphic activity scale that we validated against the actometers. In the last six months, almost seven years after the instrument was created, there have been requests from all over the country to purchase actometers. Why the sudden surge of interest in actometers? Because exercise and activity have suddenly become important in treatment regimens, and everyone needs some kind of measuring tool. Unfortunately, few companies make self-winding watches anymore, and the whole concept has to be re-thought using the new quartz watches.

So, now I am back on Mario's doorstep again, and he is busily taking apart more time pieces and other gadgets. He is determined that one day he will have something the size of a dime that he can put on elderly patients so it won't abrade their skin, and on infants so that it will not inhibit their activity. Always remember: There is more to research than procedures. There are a lot of interpersonal relationships that go into this kind of thing, and a lot of people's time and effort besides your own.

There is one innovative investigator, Jean Anderson, in Florida, who is determined to have an actometer now. She has found a jewelry chain that piles up old watches in a barrel and when the barrel is filled, gives the watches to a watchmaker's school. I believe that nursing has just produced one of the most unique types of bag ladies around. I can just see her going through those barrels of old watches. It is terrific! That kind of spirit will take us a long way.

There are real activities we can engage in that will use our energy more efficiently. I would urge you to use your master's students and the time they spend on theses more economically.

As editor of Nursing Research, I receive many manuscripts from students that really are very poor quality. Their efforts would be much better spent by participating in a piece of faculty research or by carrying out a group project that would enable them to obtain an adequate sample size. It must be very discouraging to do all that work they do, merely to be able to say that the study should be replicated using a larger sample, and then have it rejected for publication too. I don't think that this is the way we encourage enthusiasm in young people regarding research.

I don't need to remind you that federal money is rapidly disappearing, and that we need to capitalize on all the resources we have. Master's students are part of those resources.

I would like to see regional organizations, such as the Midwest Alliance in Nursing, sponsor simultaneous replications or encourage concurrent approaches to the same problem from different perspectives. Complex problems could be broken into pieces and each part studied by a different group. There is an added advantage when the data can be combined later to answer new questions.

I do not discourage secondary data analysis. There are some extremely interesting things that can come from these. Several of our students have hooked into a national data source, drawn from Health Hazard Appraisal tools, and are doing some secondary analyses on the data that are available. There is a huge pool of thousands of people who have completed health appraisal instruments. None of the data have been exploited for research purposes.

We need a variety of descriptive hypothesis-generating studies. People in clinical practice have a real advantage here. If data are collected in a systematic way, our hands are not tied behind our backs.

We have placed a very, very heavy burden on doctorally-prepared people in our field. It is assumed 100 percent of these people will go out into the profession and conduct significant research. This is not a realistic expectation, given the needs of the profession for teachers, administrators, and well-prepared clinicians. Further, it is not even a reasonable expectation if one examines the career paths of doctorally-prepared researchers in other fields.

The person who earns a doctoral degree still is not a researcher. The person may be familiar with the techniques of research and have some ideas about what seems to be a desirable line of inquiry, but lack the sophistication of a seasoned researcher.

Other fields have recognized that post-doctoral study is an extremely important component in the preparation of effective researchers. This may really upset some of you, but I don't think there are any other hurdles that can be dreamed up beyond post-doctoral study, and that may be reassuring to you. We need to begin thinking more about the possibility of a post-doctoral period in which some of our really bright and creative young people can work for one or two years with seasoned researchers; mentors who can help these students start on productive research and publishing careers.

As difficult as this may sound, I believe in the end it will prove to be one of the most effective methods we can use to produce some really significant research results. Research is not a spectator sport, or something that can be learned or appreciated from the bleachers. Getting up to cheer or "razz" the players does not help either. It means getting in there and doing something.

Excellent practice does not rest solely on research, but we do need more people to play the game on a sustained basis; many of you out there are among those who should be invited to play.

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Question:

I would like you to comment on what you believe the scope of research should be on the undergraduate level, and how we as faculty members can go about identifying research mentors for our students.

Response:

I really wouldn't try that on a large scale, even at the master's level. We have 360 master's students in our program, so you can image that a thesis is not a matter that can be considered.

At the undergraduate level, if you really believe that carrying out some kind of project is important, I would urge you to have the student tie into a critique of some piece of research that can be found in the literature. I have had undergraduate students ask what the baccalaureate-prepared nurse's role should be in research. I told one particular group, "Why don't you refine one of those studies that you critiqued and then try to do it?"

They looked at me absolutely aghast. It had never occurred to them.

I think we could do a lot to help undergraduate students understand what research is all about if we would carry it through in that way.

This is similar to having a master's student prepare a proposal, without any experience in data gathering. Consequently, they don't see the total process. There are ways to get around that without going through the thesis option, but I do think there are certain kinds of things at the undergraduate level that can be done. One of the roughest things (any of you who have completed a doctoral dissertation knows that this is so) is to identify a decent problem and put it down into some kind of shape so you can get an answer. It is frustrating enough for somebody at the doctoral level, but at the master's and the undergraduate level it is a real turnoff in a lot of cases. Not a turnoff for everybody--some people are just research buffs. They were made for it. They fall into it and don't care, but that isn't our average student.

We still want to be able to inspire in average students a feeling that research is important, and give them some sense of how to use it and design it if they are in a clinical setting. I certainly think that undergraduate students should be able to read the research literature. If we are saying that it is the entry level into professional practice, they'd better be able to read the scholarly literature in the field.

As far as finding mentors, I think this is a problem found everywhere. I face this every day, not only at the undergraduate or master's level, but also at the doctoral level. What I have to realize is despite the number of doctorally-prepared faculty we have, if they want to be promoted and gain tenure, they must produce scholarly work and research. Faculty cannot do so if they have 100 doctoral students demanding their time. On the other hand, doctoral students are not getting the kind of attention they should if faculty are caught between trying to advance their own careers and helping all these other people along the way.

Insofar as possible, we try to encourage students to take a spin-off piece of a faculty's work. I have had my own troubles with all of this. The student feels there is something dishonest about taking somebody else's work and using it. So, it is a constant struggle even with doctoral students to get them to really understand the nature of science and to use the resources that are already available to them.

Question:

Would you comment from your base of knowledge and wisdom about collaboration of PhD-prepared faculty and clinicians in nursing service regarding clinical nursing problems?

Response:

As many of you know, the unification models are very much upon us. From the standpoint of clinical specialty areas, this seems to be extremely difficult.

I have maintained that the best place to start the unification models is through a research model.

At the Hospital of the University of Pennsylvania, some attempts have been made to set up a Research Review Committee for nursing, and this is great except everybody is very inexperienced at it.

The first problems we ran into were personality conflicts, because the experts all think they know the answers. No one is really willing to pass on information in order to facilitate a piece of research. So part of what we have done is to determine that everything has to be in writing, and we are not going to have any confrontations. The whole idea of interpersonal relations suggests that the investigator should be part of the group process as it considers the worth and adequacy of a piece of research. This will cause trouble right away, but nonetheless, we are beginning to work out the bugs in the situation. I really believe we are going to be able to get some clinical research going that will be shared between the faculty and clinical staff. In fact, a number of our faculty are doing very interesting clinically-oriented studies.

Question:

I support your idea about post-doctoral work. I spent a year running around the university looking for someone to help me. I found two people who helped me, one, in of all places, a marketing department, and another in a psychology department.

Would you talk a little bit more about how you see this happening and whether it is a formal or informal situation?

Response:

We have two post doctoral students, and feel as though we are ready to enter further into this venture on a limited level. What this implies, first of all, is that you have some investigators on your faculty who are far enough into their own research to be helpful to a post doctoral person.

One of the things that has helped us most has been the establishment of our Center for Research in the school. We have someone there whose primary responsibilities are to carry out her own research and help the faculty to do theirs. She helps the faculty with proposal writing, problem refinement, writing the final products, and helps them contact people in other fields who are experts in the basic or associated content for their studies.

This person has two post-doctoral students in physiology (and soon a third one in nursing) working with her. She is also helping several of our faculty members prepare themselves for assuming responsibility for post-doctoral people. She has tried to link some of the faculty with people in other areas of the university who might be helpful in developing research and moving it along toward the stage where they, as mature investigators, are ready to take a post-doctoral person. It takes considerable expertise and decent research that looks as though it has a long-range payoff before a faculty member is ready to take on a post-doctoral fellow. The notion, of course, is that this person is really going to be a helper; they are learning, but also they are contributing to your research.

Question:

Would you comment about content or ideal preparation for the master's student?

Response:

I don't know that what we do is the ideal, but as far as I am concerned it is about as close to it as a very large master's program can get.

We began by using what is called experimental simulation (Exper Sim), which was a computer based program of research begun at the University of Michigan and later supported by Exxon. Basically, it consists of a number of models that are data based, and that have been entered on a random regression basis from a theoretical point of view. The student uses the data in the computer to design and carry out proposals. This circumvents the ghastly process of spending months achieving consent for use of human subjects, trying to find a facility that is not already overloaded to accommodate your students, and accepting all the many hours of faculty supervision required to do the job right.

I like it because it uses technology to teach in a technological age. We have a statistics person on our faculty and four teletypes in the lab. The student designs a problem, specifies the hypotheses, does the review of the literature, and sets up the methodology. Students tell the computer how many subjects they want, what the characteristics of the subjects are going to be, and what controls they want exerted. They then tell the computer to run an appropriate statistical test.

The computer then produces a printout with all the data. The students have the privilege of becoming all tangled up in their paper, discovering that they cannot break the computer no matter how hard they try, and that in all likelihood, the computer might break them before they can do any damage. They love it.

These programs, incidentially, can have concealed variables. The very bright student can come and say, "I don't think I am going about this in the right way," and "if I could just have 'x' variable to control, I think I could do a better job." The instructor can then unkey that variable.

We also have used other data collected from studies just to let students play with it. All of this costs approximately $10 per student, per semester. If times get hard, we will have to charge a lab fee. Students carry out an entire project from beginning to end. In fact, they can do this more than once; instead of spending a protracted period doing one study, they actually can do a number of studies. Also, you can develop a little scientific community here because students soon discover they have attempted to answer the same problem by asking different questions. In other words, they have learned the idea of alternative hypotheses very quickly.

Also, they intuit factoral designs to such an extent that we have had to change our teaching methodologies considerably. Students love to compare data and see how other people's answers to questions came out. Naturally, when they don't get the right answers to their own research questions, they immediately come to the instructor's office and insist something is wrong with the computer.

UNDERSTANDING ATTITUDES AND CONDITIONS THAT DETERMINE NURSES' ENVIRONMENT FOR RESEARCH

by Maxine Loomis, RN, PhD, FAAN

The Midwest is my personal and professional home; I grew up and have spent my entire career here and am very pleased with our efforts to unite practice, education, and research within The Midwest Alliance in Nursing. Today I would like to talk about our common goals, and how we can work together to achieve them. Let me begin with several basic assumptions.

First, the primary purpose for nursing practice, research, and education is to improve health care for patients. Therefore, the outcome of nursing education and research must eventually be utilized in the practice setting. Unfortunately, there currently is insufficient research available to direct the day-to-day clinical practice of nursing.

A second assumption is that clinical research requires collaboration at every phase of the research process to facilitate the conduct of more practice-relevant research. This means that clinicians must be involved in problem identification and definition, answering the design and measurement questions, working all the way through analysis, interpretation, and generalization, and eventually, implementing the findings.

The final assumption, one well documented in nursing literature, is that a large gap still exists between nursing research and clinical practice. Therefore, some sort of linkage mechanism is required to bridge the worlds of practice and research.

I had the opportunity to develop such a linkage model in my work on *The Conduct and Utilization of Research in Nursing* (CURN) project from 1977 to 1980. CURN was a five-year research development project supported by the Division of Nursing and conducted under the auspices of the Michigan Nurses' Association. The sponsorship of the Michigan Nurses' Association (MNA) was not just happen-stance. It was a purposeful plan to conduct clinically-relevant research under the responsible guidance of the professional organization. MNA's role was to involve and utilize nursing resources from the entire state.

The scientific work of the project was conducted at the University of Michigan School of Nursing and the Institute for Social Research. Jo Anne Horsley was principle investigator, and a number of University of Michigan and Michigan State University nursing faculty and students worked on various aspects of the project. The contributions of Kathy Krone, who worked directly with me on the Collaborative Research Program were invaluable. Ours was truly a collaborative relationship. A recent issue of the Western Journal for Nursing Research (1982, pp. 65-74) contains an article about resources in our hospitals and teams for collaborative research.

CURN was a five-year research development project whose major objective was to improve the practice of nursing through two types of activities: 1) utilization of existing research findings in the daily practice of registered nurses, and 2) the design of research conduct which was directly relevant and readily transferable to nursing practice activities.

The first of these activities which is referred to as the Research Utilization Program, was directed by Joyce Crain. Some of you may already have seen some of the innovative protocols that are now emerging from that research utilization portion of the CURN project. There is also a workbook which is in final editing stage now. Perhaps by our next convention the workbook, which moves people through the research utilization process, will be available. This would be an excellent reference to consider for those teaching at the baccalaureate and Master's levels. At these levels a productive approach to consider is teaching with a focus on research utilization. Nurse students can thus become knowledgeable consumers of research literature, and know when, and when not, to implement a practice change based on research findings reported in the journals.

COLLABORATIVE RESEARCH PROGRAM

The second and smaller portion of the CURN project was the Collaborative Research Program which I directed. If there are questions later about the research utilization portion of the project, I will try to provide answers although I was less involved with that particular area.

The collaborative research development model that we designed took the following form: Collaborative research development grants were made available over a two-and-one-half-year period to a small number of collaborative research teams composed of at least one nurse clinician and one researcher. The stated purposes of the grants were to promote the conduct of collaborative research by jointly engaging nurse clinicians and researchers in the development of research plans; also, to promote the conduct of relevant clinical nursing research, which could therefore be more readily transferred into practice innovations.

Let me underscore something that consistently confused people in Michigan, even those of us on the project at times. What we were funding was a period of proposal development. We were not funding the conduct of the proposed research. Therefore, we had to set up slightly different criteria and operate somewhat differently than the traditional funding of research project.

Those of you who are familiar with the process of applying for a grant and obtaining money to study a problem know that CURN's operation was nontraditional. We funded clinician-researcher teams and were involved with them during their proposal development. They then had a proposal which they submitted to other agencies for support and funding of the actual research.

The collaborative program through the Michigan Nurses' Association provided one half of the resources necessary to design the clinical research. Matching funds were provided by the team members' employing organizations as a means of insuring organizational support for their work. Funding was divided into three stages with one third of total grant awarded upon successful review at each the stage. We really wanted a chance to interact with the teams and monitor or facilitate their progress throughout the process.

Five teams, with a total of six researchers and 14 clinicians, comprised the collaborative research development personnel. Data regarding the process was collected through formal questionnaires, structured interviews, tapes, minutes of team meetings, staff observations, and a summary workshop involving participants in the program.

The research goals we had, as staff for the collaborative program, were to gather descriptive data on the advantages and disadvantages of the collaborative research development model for generating practice-relevant nursing research, and to provide data on the structure, process, and outcomes of collaborative research development which have implications for research utilization.

The following is a summary of our findings. Of the six researchers participating in the study, four brought expertise related to the clinical content area under consideration. Two of the members brought research methods and data analysis expertise to the team, but in the beginning were totally unfamiliar with the clinical question being studied. Three of the researchers were doctorally-prepared, non-nurses -- two teaching in public health, and one psychologist teaching in nursing.

Among the three nurse researchers, one was doctorally-prepared and the other two completed their doctoral work during their involvement with the collaborative program. Their doctoral work was in addition to, and not part of, the collaborative program.

The average professional experience of the research team members was 20.8 years, and the average post-doctoral experience of those with doctoral preparation was 8.5 years. A total of 14 nurse clinicians were members of the five collaborative teams, for an average of 3.25 clinicians per team.

We asked the teams about this and got a variety of interesting answers. I am not sure there is any one explanation, but it seems that those teams with three clinicians were used to working in groups, and wanted the support of other clinicians on the team. Secondly, they used the project in part for staff development. For example, they would say, "Well she is going back to school pretty soon, and she could really get something out of this, as well as contribute something to it."

The two-member team of a clinician and a reseacher had already been working together in the same setting. The research member was also an excellent clinician herself and was doing research with some of the same youngsters with whom the clinician was working. The other four teams ranged from two to five clinicians per team, and the average professional experience of our clinician members was 11.9 years.

The description is intended to give you a mental picture of what some of these teams were really like. All of the clinician members were nurses with some personal latitude in scheduling their time and determining role expectation. This is extremely important and I will come back to it. Only one clinician team member was a staff nurse, and this person worked on a parttime contingent basis because she also was enrolled in a graduate program.

Two of the clinician team members were directors of nursing, who had expertise in the content area. They were not on the team by virtue of being directors. Four had clinician or clinical specialist titles and two were clinical coordinators, which were supervisory-level roles in that agency. Two were head nurses and three had special role titles, such as perinatal nurse educator, infection control nurse, or nurse enterostomal therapist.

The educational preparation of the clinical team members demonstrated a consistent pattern. Six of the clinicians had master's degrees in nursing, five reported BSN as their highest degree, and three were diploma graduates. All three of the diploma graduates and all three of the BSN clinicians were enrolled in degree programs during their participation in the collaborative research team. What we had were people with unique, flexible roles who were very committed to the whole process of learning. We did not choose them; it was a self-selection process. They chose to be involved in the program.

The teams had contact with Kathy Krone and myself for an average of 23 months. During this time, there were 60 team meetings, with each team meeting an average of 12 times. We attended a total of 24 meetings, averaging about five meetings per team.

We began by meeting with the nurses who had responded to our request for clinical research proposals and tried to help them define their clinical problems more clearly so we could get some idea of how best to help them align supportive resources. At the start most of the clinicians did not know the researchers who could best help them. In many cases there were difficulties because the clinicians had focused on a very specific clinical problem. Our task was to search the state to find a qualified researcher who could help them study that particular problem. This was how we fulfilled the linkage function for the teams, and it was not always easy.

Let me give you some idea of the proposals finally developed. The first team wrote a proposal to study, "The Impact of Primary and Team Nursing." The second team focused on what they called, "Reduction of Confusion/Disorientation in Elderly Patients." The third team's study was entitled, "Activated Monitoring Systems: A Nursing Approach to Long-Term Management of Pulmonary Patients."

The fourth team proposed to study, "The Effects of Clean vs. Sterile Catheterization on Infection Rates in Hospitalized Rehabilitation Patients." Team Five's study was "The Psychosocial Response of Children and Their Families to Intermittent Catheterization."

We did demonstrate that it was possible to link clinicians and their practice concerns with researchers who could and did collaborate in the development of clinical research proposals. By Fall of 1981 two of our teams had applied for and received federal funding to conduct their studies. In addition, two teams applied for foundation support, and one team submitted a report of its pilot findings and methodology for publication. That was the team that was studying confusion and disorientation in the elderly.

Once they defined all of their variables, they decided to do a pilot study of the incidence and prevalence of these phenomena in their hospital. As a result, they found that the incidence was not really that remarkable.

They found that when someone was confused and disoriented, stumbled out of bed, fell down or got into trouble, that in itself it was a remarkable incidence, but the frequency was not enough to plan a nursing intervention and demonstrate a statistically significant change. They did not turn in a proposal but instead reported the way they defined their terms and the kind of protocol they used to check for incidence and problems--a useful contribution to other researchers studying this problem.

Our data suggested a composite of conditions which were supportive of collaborative research development. The nursing practice environments had a variety of stimulating resources available, which the nursing staff reported using. Within this environment, experienced, degree-prepared nurses with more autonomous and flexible roles were able to utilize available resources and collaborate in research development process. The research collaborators were nurse researchers developing an area of research interests with no established research program in place, or non-nurse researchers ready to expand their content or methodological expertise in the area of nursing practice.

Our process was unique. Usually, it is a researcher who makes up a plan or proposal, or a student who needs a study and tries to conduct it in a hospital setting. Normally, the researcher or student tries to convince the clinicians that their research question was really worth doing in the clinical setting. Instead, we went through the hospital's front door. Our first contact was with directors of nursing. Clinicians took the initiative in defining the problem.

Finally with regard to the Michigan experience, our teams also reported the need for a variety of support mechanisms if collaborative research development was to continue in the absence of our project. Funding for release time and technical support was essential. The basic funding available through the collaborative program also provided the teams with visibility and credibility within their own institutions. There was a reported need for linkage to resources not available within each team (such as statistical assistance), through a communication network which would link them to others involved in similar work, and to outside consultants.

We held three workshops which all members from all five teams attended. At first we were concerned that teams might not be willing to spend the time to come together and help us get more information regarding the similarities and differences in their individual processes. Instead, we found that they loved it and might have held the workshops themselves had we not scheduled them.

Through these workshops they became resources for one another. If one team found an article that related to the subject another team was studying, they would pick up the phone or mail it across town. This was an exciting aspect of the work with them.

After my three years of experience with the CURN project, I am convinced more than ever of the need for an integrated approach to nursing education, practice, and research. Since the mid '60's, which is really the beginning of my career, I have been a strong advocate of joint appointments.

What I am proposing now is an alternative approach; the advancement of nursing practice, nursing education, and nursing science through the collaborative research development process. My switch from the concept of integration to that of collaboration may not sound major. It does not imply a change in philosophy as much as just trying a different approach. I think it is important to note, however, that I believe all the integration models we have developed require the blending of roles within the individual nurse. Thus, clinicians are also educators, and researchers are clinicians and educators, and so on. This model is fine for those individuals and organizations who can make it work. I think we have some excellent examples of where it has worked, but it has not worked for everyone, and I am not sure why. This is an area for further discussion.

Integration has not worked for all nurses, nor in all clinical or educational settings. Perhaps other models need to be explored, matching the most effective model for each setting. Not all researchers are practicing clinicians, and not all clinicians are prepared to conduct independent research, nor should they be expected to do so.

It seems that collaboration is a viable alternative. The collaborative research development model has several important and unique features. First, the model is designed to utilize the unique capabilities of clinicians and researchers. I am assuming that in most settings researchers are also educators. Of course, that is not always true, but in the majority of cases it is.

Our data from the CURN Project indicated clinicians and researchers expected to bring different expertise to bear on the task of developing clinical research proposals. They structured their work accordingly and gave us clear feedback at the close of the project that, indeed, each member had brought unique knowledge and skills to the team's work. They all came to value and respect one anothers' contributions.

A second feature of the collaborative research development model is that it is driven by clinical problems, thus, increasing the clinical relevance of the research project. With clinicians involved as equal team members at every phase of the research process, the topic of study is more likely to be of clinical importance and the results more likely to impact clinical practice. By the way, that's an assumption or assertion that needs further testing.

Thirdly, the collaborative research development model does require a system of organizational supports. In Michigan we found that our collaborative hospitals had a variety of research resources, and staff reported using them at a significantly higher level than other hospitals. These included a professional library, release time for professional development activities, and involvement in graduate student and physician research. It is also important to note that all clinicians on our teams had flexible, autonomous roles; most were actively involved in formal education programs while working.

All of the researchers held faculty appointments in major universities. I have given a great deal of thought to this as Director of the Doctoral Program in Nursing at the University of Illinois, and tried to determine how, without federal funding, we can expand collaborative research development. Currently, colleges and universities are involved in a process of determining their research priorities for the next few decades. We are committed to establishing our research in conjunction with clinical agencies. As a result, I have been focusing my attention on implementation strategies.

Successful collaborative programs will require the administrative commitment of the chief nursing administrators in both service and education settings. Nursing, budgetary and practice control must be available to provide release time, research support resources, and protect the clinical and research integrity of the collaborative teams.

Our experience on the CURN Project taught us that it was essential to have early contact with the director of nursing, who was then able to facilitate subsequent administrative and clinical elements of proposal development, including confrontations with physicians who didn't like nurses using "their" patients.

We had some interesting confrontations, with regard to release time. If we were going to pay people to assure time for proposal development, I wanted to make sure that they weren't getting called back into the unit during research time. We got all that negotiated and arranged, but clinicians, by their nature sometimes wouldn't take their release time. They kept sneaking up to the units, or attending important meetings, and would wind up working on the project on Saturday or in the evening.

I would ask, "Do you need any help? Do we need to go back to your director and renegotiate?" They would say, "No, it is my own fault. I am just not taking the release time." I have not figured out how to solve that problem of giving people release time when they won't take it.

At the University of Illinois, College of Nursing we are exploring several options for administrative contracting for collaborative research development. One alternative would be to contract on a per-project basis for the director who has identified a relevant study that fits the expertise and priorities of the faculty. Currently, we are undertaking such a project to develop a Quality of Nursing Care Index with one of our local hospitals.

Another approach would be the mutual service/educational development of ongoing programs of clinical research to which both organizations would subscribe over a period of time. At present, we are involved in developing this kind of process with our own university hospital. The research would allow the college and hospital to target clinical research and educational resources to generate substantial knowledge.

Collaborative research development in defined areas of nursing practice will require certain changes in both the practice and educational settings. Within the CURN Project we found that each of our collaborative teams utilized an inductive approach in designing their study. Despite an initial belief that they had defined a serious clinical nursing problem, each team, through its own process, decided to back up and document the existence and nature of the problem. In each case the problem definition was altered by this initial exploration. Only after empirically identifying the problem were teams comfortable in searching for alternative methods of research regarding their problem.

We all became painfully aware of the inadequacies of traditional physical and behavioral science experimental designs for investigating the questions of concern for clinical investigators. An inductive approach to the definition of clinical problems will likely impact the methods and data analysis strategies we presently teach our students. Qualitative and descriptive methods will take on a new importance, especially in researching areas in which we know very little.

There may be certain clinical questions that will never fit into an experimental or even quasi-experimental design. We will no doubt place a great strain on our researchers to develop new methodologies for exploring human health problems in naturalistic settings. I only hope they are up to the challenge, because the possibilities are exciting.

Each of our collaborative teams also experienced considerable difficulty in operationally defining their dependent variable. For example, what are the patient outcomes that you would expect to impact through a certain nursing intervention? How can those be measured? The teams all confronted the lack of clinically relevant and usuable instruments for measuring phenomena of concern for nursing practice.

The operational definition of the independent variable was no less a problem since the independent variable in most cases was: What is the nursing intervention? What is the new item inserted into the situation to affect the outcome? Here they were forced to directly face the ambiguities of nursing practice in each of their respective settings: What was the current nursing practice and in what ways did the proposed intervention differ?

Ongoing research involvement in the practice setting will force us all to clarify our definitions of nursing practice, nursing inventions, and the impact on expected patient outcomes. I do not think we are going to do this separately; I think we are going to do it together. If we are to accomplish our professional health care objectives this means we must structure an incentive system which rewards collaboration.

We can no longer afford the luxury of educating students for clinical roles that do not exist, practicing nursing in a way that defies documentation, or conducting research with methods and instruments which lack clinical relevance. Our graduate student and faculty research must focus on clinical problems generated from within the practice setting.

What I am proposing requires close collaboration among clinicians, educators, and researchers. Together we must define nursing practice in operational terms. We must define the outcomes of nursing practice so they can be measured. Our goal is similar: the generation of knowledge will result in the best possible nursing care for our patients.

REFERENCES

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Questions to Maxine Loomis

Question:

I wonder in your collaboration with universities and hospitals if you have any comments on the functions of a committee regarding the protection of human subjects in a hospital as similar and/or different from the similar committee in the university.

Response

I have some personal opinions about that. Our experience in Michigan was that the CURN Project was really very active in helping hospitals to develop their own committees, so I don't have as much experience with being able to say yes, this got past the university, but it never got past the hospital or vice versa.

The CURN Project was implemented in various locations in Michigan for five years, and during that time we really did a lot to increase the research awareness of people in the state. We helped several hospitals by providing guidelines and information about how to set up their own committees. I rather like the idea that there are committees at both ends. I think we need more experience with each other. At this point it seems as if clinicians are looking at slightly different issues than faculty members in the realm of protection of human subjects.

I am always excited to find that the hospitals have their own committees, because it indicates they have some research knowledge, awareness, and interest. Maybe at some point, we will wind up with some joint committees, because it is a hardship on researchers to go through dual approval processes.

Question

I am wondering if the release time concept is going to be a disservice. The reason I ask this is that I hold a belief that education, research, and practice are one role and not three separate roles; the percentage of time in those may vary according to priorities.

Secondly, if as in the CURN Project you found these clinicians could make decisions about role development, then why do we need the concept of release time and won't that be a disservice in the next decade?

Response:

What would you put in its place? You and I both know it takes time to get to the library and read. We can't keep doing research on our lunch hours and weekends.

Question:

When people ask those kinds of questions can we not say to them, "You do make decisions about your priorities." It is well accepted that this varies over time. It depends a lot on the current situation with regard to funding. It will not succeed unless research is built into nursing roles and people understand that nurses may be independent decision makers. We are not talking about nursing assistants, but well-educated people who know their priorities and who are expected to be decision makers. It bothers me as a director of nursing service to think they need that kind of support from me. It is their job to make those decisions.

Response:

I think you are a unique administrator. Part of our reason for considering release time and framing it in those terms was that there are still nursing colleagues among us who want to know where you are and get very upset when you are not on the unit.

It isn't just directors of nursing, but also supervisory level people such as head nurses. I do know that there are some schools of nursing where they have the equivalent of keeping your faculty barefoot and pregnant -- I don't know how else to say it.

They are swamped with clinical hours and clinical students and are required to be in the agency every second the students are there. It is for that group that doesn't have as benevolent or enlightened a leader that I think we still talk about the notion of release time.

Response:

The most ideal year of my life occurred when I was on sabbatical a couple of years ago. What made it ideal was not just that I had time to write, but, also that I had a parttime clinical practice in Ann Arbor.

So I had my clinical practice going, I was wrapping up my CURN Project work, and getting into more clinical research of my own. In the process of all that, I had several doctoral and master's students that had been working with me, and there was nobody else to whom they could shift. Even though I had had joint appointments, it was really the first time I experienced the integration of my clinical work, my research, and my teaching, partly because I just wiped everything else out of my schedule that didn't fit. Now I know even better where I'm heading, what I would like our faculty to experience as well, and how to get those roles blended for those people who want and are able to do it.

In the meantime, I am considering a collaborative model because I realize that there are some people who are not, never will be, and maybe never should be researchers or clinicians. My notion is that educators should be doing something else in addition to teaching, whether research or practice. I'm not really fussy, but they need to be out there actively doing what they are teaching. I have been trying to develop other models to facilitate this for people who, for practical or personal reasons, can't really integrate all three of those roles.

Question:

With regard to expectations and release time and Florence Downs' presentation, I think clinicians are kind of lost as to what their research expectations are and whether or not they have resources in their setting. I also think that someone ought to write an article on, "What is Administrative Support?" I think that one of the important things for me in joint and clinician roles, is an administrator who can say to me, "I expect that you will be doing these things: practice, education, and research. How you divide up your time is your choice."

Response:

When you were commenting on support, I agreed with you. Support is one of those things like when little kids ask, "Mommy, how will I know when I fall in love?" And mommy says, "Oh, you'll know." How do you know you have support? You know when you have it. You know what that experience is like.

I think it is imperative not only to our own objectives, but also, to the agency to build in a mechanism for review and feedback. Whether you want to call that peer review or management by objectives, there are lot of different procedures for getting that feedback. I think you just need to acknowledge that we all need it and build it into the role.

Question:

It occurred to me that that the usual way of going about it in academic circles is for faculty to seek external funding for a project. Can this also not be the route for nursing service administration to consider? Would this encourage their clinicians to seek external funding?

Response:

I think that is an excellent idea. The larger the project, the more need for external funding. The problem right now is where to find the external funding. However, even assuming the nursing research budget stayed the same or grew over the next five years, we are going to need to do some work on the criteria upon which proposals are reviewed.

We were very concerned about that with the two CURN teams that submitted requests for federal funding. You know more than half the team members were not doctorally prepared and had no research track record. In the competitive research marketplace, their resumes just didn't look like those of the doctorally prepared people with whom they were competing. It was something that concerned us and is going to continue to be an issue if the federal government starts getting more and more applications from hospitals.

When I was talking about hospitals and schools coming up with programmatic areas of research, I think this would be one way to facilitate funding as well. We have been considering some ways of trying to get just some internal seed money that could be used to get the pilot started, and the instrument developed before it is ready to go out for external review. There is no doubt that money helps.

There are ethical concerns, too. Research in hospitals, as I am sure some of you have considered, will increase the cost of patient care. Is that where the money should be coming from or not?

Question:

Every industrial agency turns money back into improving its products. The product of hospitals and health care agencies is service, and research is ostensibly used to improve the service. We should get rid of this notion that we don't deserve to have support for nursing investigation.

Look at the money that is poured into support for medical research. We don't think that is bad.

Response:

Yes, I do.

Question:

Well, I don't, because I think that the persons who are going to benefit are those who are served by those institutions in something called medical service, nursing service, and dental service.

Similarly, the product or goal we have in education is to educate the next generation of people. The more knowledge we have to transmit, the better our educational product is going to be. I think that we have to get over this notion that we shouldn't expect that people will, in part, advance knowledge. If I were in an administrative role in a school, I would expect that they would have a contribution to make to improve education, and that in turn would improve practice.

Response:

I agree that that is the expectation; however, I usually do disagree slightly on how it gets funded. I believe that we do not have enough controls built into the system. It really worries me how much people are paying for health care already; I don't know that people can afford any more. People who need care already are not getting it.

I agree if we had an industrial model where there really was a research and development department that had to prove its own worth and some way of measuring the cost/benefit ratio of the work of that Research and Development program, then fine.

My concern is with supporting programs of research for five and ten years that aren't coming out with anything that is improving patient care. This comment applies to medical research as well. I don't know that we should be supporting all of their research, either.

Question:

I think this is a very sensitive question. I really believe in what the previous person said, that the research has to be relevant. You have to look at that piece of research and say, "We expect immediate feedback into patient care." People want to come and do their research that does not connet to our patient population.

Knowledge for knowledge's sake is a difficult question in clinical settings. We need to hang together to improve practice, but with concern for the reaction of reimbursement agencies who may say we will not be reimbursed for activities not directly related to patient care.

PANEL PRESENTATION:
Why Aren't the Advances of Nursing Research Being Implemented at Bedside?

by

Judith Floyd, RN, PhD

Phyllis Kritek, RN, PhD, FAAN

Susan Reisch, RN, PhD

Karen Kirchhoff, RN, PhD

Judith Floyd:

When one asks "Why aren't the advances of nursing research being used at the bedside?" there is an assumption that there are research findings that could be used at the bedside. It is apparent, as I look at the research journals in the discipline that there are only a few findings which are useful in my clinical setting. Also, within my specialty of psychiatric/mental health, practitioners are more likely to read a journal that directly addresses the clinical problems with which they deal. These journals publish little of research or discussion of interventions that are derived from research-based knowledge.

Given this, I determined what I would like to see in the journals that influence me most in my practice. There should be a discussion of interventions--generated from bodies of research knowledge--that have been systematically evaluated in clinical settings similar to the one in which I practice. Unfortunately, this information is not available. The state of the art in psychiatric nursing research has not developed to this extent.

Nursing research may be more developed in other specialties. I do see, within the CURN Project for instance, effort being made to identify research-based bodies of knowledge from which intervention protocols can be developed. However, we have yet to move toward systematically evaluating these few protocols that have been developed. If we are on the right track, it is still going to be some time before protocols are developed that can be safely implemented at the bedside.

In terms of research findings and utilizing these findings we have two different approaches being taken. First, we have people who do what I term, "evaluation research". They ask questions such as "Does this work?" Although it is not always the case, the manner in which evaluation research is conducted often cannot be generalized. Instead, information is generated that would be useful in making decisions or in forming policies or procedures in one specific institution. We do a fairly good job of sharing this kind of information, and I think that other nurses in decision-making positions do take a look and say, "This is what was done in that institution. Our institution is or isn't like that institution." Thus, is some attention to sharing and using the knowledge generated by this evaluation research process.

Secondly, there are a few established researchers who have taken on the task of identifying an area of clinical research and gone through the slow and sometimes painful process of identifying the salient variables. They have tried to measure variables and outcomes, and suggest ways in which the results may or may not be useful for practice. At this time, however, even the best of those endeavors has not produced anything that I can safely implement in my practice. If that is so, how can research findings be implemented at the bedside?

Research, which I distinguish from evaluation research, has as its basic purpose the testing of theory, or in our case, the building of theory. So, what we should expect of researchers and their work is the development and testing of theories which can guide practice.

There is a lack of critical review of the theories currently being used to guide practice. The contribution of much of nursing research, given the present state of the art, cannot be direct implemenation at the bedside, but can in the educational setting where theory is taught.

We need to present the theories that have some hope of application to the particular clinical problems being addressed. There are a number of theories that may have some application to clinical nursing problems. We should look at the state of development of those theories. I hope that the practitioner's practice is based on theory, and that (s)he is asking, "How good is the theory upon which I am building my practice?"

If clinicians come to grips with how little scientific knowledge there is within the discipline, they might be more eager to read research journals to find out how well their favorite theories are holding up under testing through research. Much of what we learn, both in formal education and continuing education, is a time-honored theory or model, but without the scholarly appraisal of the state of development of that theory or that model.

One suggestion for the next few years is that we make an effort in generic programs, and in continuing education, to teach more about the critical testing of theories through research. I believe that if we do this, practitioners will base their practice on empirically tested theory. In that way research findings will indirectly impact on bedside care.

Karen Kirchhoff:

Since I am a researcher I decided to approach this presentation by means of data collection.

Recently, I was doing some inservice work at a hospital with some clinicians and administrators. We were looking at the problem of research utilization. I had them respond to the following questions: (a) "Have you used any research in the past six months; (b) If yes, what was it and what did you do; (c) If no, why; and (d) What do you perceive as obstacles in the utilization of research? Then we did a categorization of the responses together on the blackboard.

Out of this exercise we established three categories: the clinicians, the research report, and the researchers. This was to help us focus responsibility most appropriately. Next we put down all problems. Most responsibility seemed to lie with the clinicians. We found the usual list: lack of time, lack of understanding, lack of awareness of studies in their respective areas, lack of confidence in critiquing studies, and lack of a resercher who could assist me.

In addition, some other interesting comments were: "there is a resistance to change," "The change affects not only me, but also many others," and "Couldn't we wait for the research findings to be developed into policy and procedure?"

Research is not a part of a nurse's daily routine. In my own research to determine nurses' awareness of studies conducted in the critical care area, I found over half of the nurses who responded were aware of the research findings. The questions they were asked implied they had changed practice on the basis of those findings. The results indicated that although over half of the nurses were aware of the findings, they had no impact on their practice.

This seems to indicate that researchers believe their work is done once it is published. After all, it is all there, and if the clinicians just read it and do it, findings would be implemented in practice.

Responses regarding the second of the two categories, indicated that the research report (and Dr. Downs gave us information about some of the research reports this morning) may be part of the problem. This group questioned the availability of studies, and was unsure which of the research reports should be utilized.

The CURN criteria for research utilization includes a statement that there must be a replication of the study. One-shot study findings can not be utilized. The second criterion is the scientific merit of the study. Is it worthwhile to utilize the study? The third criterion is the risk of the outcome. What happens to the patient if we decide to do this?

The fourth is the practice relevance. Is there clinical merit to the study? Is the intervention under our control as nurses? Is it feasible and what is the ratio between cost and benefit for that study? Does it hold up when tested in that setting with those patients? Or does it hold up in a Veterans Administration Hospital setting with only males?

The third group that has responsibility is the researchers. Ketefian says that most of nursing research has not been cumulative. Horsley, too, asks if there has been sufficient replication. Nursing research in general has not been program-oriented. As a result, researchers are not consistent in the types of studies that they do. The studies vary in content areas and, therefore, are not building upon an integrated knowledge base.

Educators, too, bear responsibility because they may ignore research in their content areas. For example, when we teach vital signs, do we relate studies that have been conducted on length of time an oral thermometer should be kept in place? Do we speak of Nichol's (1982) work when we discuss taking the temperature, or do we simply tell the student how to insert the thermometer? When I was working toward a physiology minor I was extremely impressed with the way the courses were taught and the procedural information presented: When solution A was added to solution B by an investigator, he found this particular reaction. Then, another investigator came along who tried something else. All of the content was given to us through the results of studies, and not just as straight content.

How do we handle our students in the clinical area when they ask questions? Do we encourage them, or do we tell them this is the way it is done, or this is the way you have been told to do it?

Recently, some of our staff nurses were discussing which positions the patient should be in for a mean arterial pressure reading and which site they should use to establish baseline values. Should they be using the catheter site or the right atrium? It just happened that the director of nursing came in on this discussion and said, "Why don't you conduct a study?" Now that is what you call administrative support! Right now we are in the process of doing data collection to answer that clinical question.

It has only been in the past academic year that our master's research course has begun to spend two hours on research utilization. We spend the first part of the class in critique of particular studies, and I deliberately choose two with contradictory conclusions, and then I ask the students to come to a practice decision. Then we spend the last half of the class dealing with what needs to happen in order to implement those changes in practice.

Also, when students decide to do studies, do we as educators value replication as much as we do an original study? In my educational experiences, I chose to work with an investigator and apply her hypothesis to a different population. For that I ended up with half the credit hours because it was not an original idea, and I was not allowed to call it a thesis, but rather a research practicum. It was still a good experience, however.

I have some additional comments for the researchers. What are the sources of the research questions? If the research questions are relevant to the clinicians, they will use the results. If there were more interchange between the clinical settings and the researchers, researchers possibly would study more relevant issues. When research is conducted in the clinical setting, how are the clinicians who eventually will be using the results involved? Is the input they give to a study valued when the study is brought into a clinical setting?

There needs to be that interchange before things are finalized, before the student's thesis is approved. We have had some very negative research experiences when students were unable to change thesis ideas or subject criteria when it really didn't match our setting. One particular student ended up having a very low sample size because she could not make adjustments in her thesis.

Will clinicians use the results of research to which they have developed negative impressions as the research was brought into the setting? The fact is that studies being conducted in clinical settings impact upon how that clinician uses the results of that and other research. There is concern that educators and graduate students may neglect issues of importance to clinicians.

Probably the most important issues right now in the clinical setting are financing, budgeting, and staffing. How will research be conducted in the midst of those pressures? Few researchers are addressing these problems.

At the University of Illinois Hospital we have done some positive things to change the context of these problems. For example, a pediatric faculty member invited me and several others to tell her students about University hospital's current research interests in prediatric nursing. I talked to one of our assistant directors and got some topics from her, met with the pediatric students, and suggested these topics. One student decided to pick up on a topic, came into our setting, following up on a suggestion of the assistant director, and could walk right in and do the study.

One student did a study that some of our head nurses and assistant directors wanted to be done on the effects of self-scheduling. The two comparative models were "self-scheduled" and "head nurse scheduling." The student completed her thesis, the head nurses and assistant directors got needed answers, and the whole unit decided, on the basis of the student's findings, that self-scheduling was better. There was immediate utilization of that research, and the student had an extremely positive research experience.

In conclusion, we need more in-depth research reporting. As exemplified in the CURN project, a number of studies should be done on particular topics.

Another suggestion is that groups should develop a research-based policy and procedures manual. It is always a large burden for institutions to develop on their own. The policy and procedures committee chairperson at our institution is always asking me, "Are there any studies on this because we want our policies and procedures to be based on research?"

For research utilization, we may need a new brand of individual who will have not only the research skills, but also the ability to translate the studies into terms that can be utilized by clinicians.

Phyllis Kritek:

I would like to preface my remarks with a statement that I am to some degree influenced from an experiental standpoint, having worked as director for our Center of Nursing Research and Evaluation. For any number of reasons, the Center emerged out of a faculty research development grant for which our current dean, Norma Lang, served as project director.

It began with a strong interest in what is now referred to as an integration model, working cooperatively with service and education. We always have intented to look at how educational settings and service settings might interact, and so that greatly influences my approach to the question.

I am also more interested in what works than what doesn't work, and more impressed than discouraged by nursing research at this point. Maybe this is a disclaimer. Often I think we would benefit from a conference entitled, "Let's Tell Each Other How Extraordinary We Are."

I am not sure that nursing research is always the only way to solve clinical problems. In some ways nursing research may appear more methodologically elegant or complex, but I am not always convinced that those methodological decisions are necessarily appropriate to the question that nursing has to ask. It sometimes reminds me of adopting methods like we adopted team nursing. There were so many good articles on it at the time. I do think we still have some real struggles with paradigms. We struggle in our disciplines with models for cooperative scientific endeavors -- important struggles to view critical inquiry as a collective trait of the profession, not as the unique trait of the sub-group within.

Nursing research though, still appears a somewhat isolated, fragmented, and methodologically diffuse activity. Despite this, I would like to respond to the topic by saying it is multidimensional; and three aspects are important: educators, service persons, and nursing literature continue to have a basic pattern of what I refer to as, "parallel plague": You do your service, and I will do my education, and we will try to eye each other from the side. Hopefully, everything works out and we don't fight because people talk about us when we fight.

Regarding the educator, there are some very critical dilemmas with which we must grapple. Though we give a good deal of lip service to the research process and its importance in our curricula, research content is not given credence, particularly when we question the role of research in undergraduate education. We tend to to criticize research or assign students to conduct little mini-studies rather than determine how we might teach undergraduates to reconceptualize nursing. We fail to ask, "To what degree has the research I am about to do been empirically grounded, and in what sense and degree?"

Personally, I find it uncomfortable to get up and lecture, nevertheless, I do lecture to sophomores on the "interself-concept." I usually tell them, we do not really have anything that I consider grounded theory in nursing research. Instead, we have only opinions at this point.

Something I see more and more is literature that says nursing is very concerned with autonomy. I see a tremendous number of master's students and, indeed, faculty and clinical people, who become interested in research. They decide its the place they are going to exercise their new view on the autonomous role. Their inability to work with others hampers the achievements of all of those groups. Sharing the work and the confusion and perhaps, the embarrassment of our own lack of development, becomes so uncomfortable that the problem of, "this is mine" becomes serious. We have difficulty with cooperative efforts in this category.

Replication has been spoken of frequently so I won't reiterate except to say that I strongly believe that it is a serious issue in master's programs. I do think that replication study is not given credence, yet is critically needed if we are going to develop a foundation for the positions we take regarding intervention.

There is also a need in education to improve the socialization that we engage in relative to the research process. An enormous number of students will perceive the research process as unpleasant or difficult. Research is something done to explore those areas of practice that are troublesome. This is a different approach to research than is respresented by the person who approaches it to discover the new and exciting.

Finally, in terms of socialization, there are important values that any scientific endeavor has to regard as important if it is going to continue to grow, and these values need to be legitimized for all nursing. The value of tentative answers rather than the myth of the "one best way" is a very critical value--a value placed on systematic doubt or on nagging curiosity. Generally, these are not values that are rewarded within the profession.

Even the question of getting things to the bedside has a kind of message for which you are supposed to have an answer as quickly as possible. The ability to continually question is not as important for a lot of people as the ability to continue to feel like they have the right answer.

Obviously, I am not sure the line for me between education and service is a dark one all the time. Much of what I have said applies to both settings. In the practice setting we have not moved well past anti-intellectualism or cognitive-temerity and, therefore, are not willing to look at the issue of research as a professional collegial group. There are real issues relative to resources, time, climate, expectations, and deliberate planning to consider.

This morning I responded to the discussion about release time. In reality, we don't tell people that they should now do a new activity. It is sometimes a creative sensation within individuals which motivates them in the direction of research.

If any kind of change is going to be instituted, it does take deliberate planning. It takes structuring of rewards, the opportunity to make mistakes along the way and, it takes the resource that I call encouragement. I send out "scratch and sniff" stickers with pizza on them for people who get proposals out. It's a standing joke, but people like those scratch and sniff pizzas because they are fun, and at the same time represent concrete statements that someone notices.

The issue of resources is real in the practice setting, as is the issue of skills in the practice setting.

Regarding the literature, it appears there is very little research synthesis. So when you ask someone to find out everything there is on catheterization, she may find 40 conflicting mini-studies. We do not have a format for research synthesis; the only place it is systematized is at the doctoral level. We don't seem to put a value on synthesis of nursing research.

Also, there is a chasm between the kind of empiricism of journals such as Nursing Research, and the page many of staff nurses tell me is very useful in the American Journal of Nursing (AJN) about interesting things other people and hospitals are doing that work. ("Creative Care Unit" - AJN). It is having an impact on practice. Somehow the presentation of research isn't working when a page in AJN has an impact and our empirical studies do not.

I would like to tell you about observations the Center has found valuable or valid, some of the things we have tried, and, also, some "generic" items.

Obviously, replication is a big category, and you have heard it now 18 times. By now you are convinced it must be important, but I think it is also an economical tool fot small agencies that say they can not afford to develop a research center in the near future. However, what if in a given community, such as Milwaukee, we had eight hospitals participating together in either clinical trial research or replication of a specific study. Would that not be a very cost effective way for many agencies to have an opportunity to participate in research?

This could "make it happen" in their respective own agencies, and I am convinced utilization is tied directly to feeling you have a stake in the process and outcome--to say nothing of utilization. Cost is a convincing problem and multi-institutional consortium-research could be powerfully cost-effective.

Faculty and clinical personnel frequently work together on studies. A useful model has emerged which helps us identify what each group brings to the task. The clinical agency brings the components of problem identification and research implementation, as well as final validation. It is agencies that are able to tell us that it is a great idea, but it won't work. They help keep us honest relative to the nursing enterprise.

The schools bring design protocols, instrumentation, and data analysis resources. We have had some contracts where the clinical agency does its part and only data analysis is purchased from the Center, because that may be the only part they need from us. We have negotiated collectively to share publication rights in instances where many people are involved from both the agencies and the schools. Those kinds of studies are giving us ideas of models that might work.

There also is an organizational theory of program implementation called "muddling through." At times I think we use that model almost exclusively. There is a risk involved when you live with the uncertainties of how the project is going to come out. The risk, however, is worth taking when there is positive outcome for everyone involved. It as a win-win situation; we all receive a positive reward.

Through the process of working together, job satisfaction and the capacity to understand each other's world has increased for both groups. Florence Downs was correct earlier today when said she saw the whole integration of service and education emerging through research. I would very much support that observation from my experiences.

We have some agencies where the contract is to purchase a portion of the faculty person's time to aid in research facilitation. We call then research liaisons for want of a better name. The clinic has compiled statistics, through consultations to agencies and workshops, on possibilities for clinical research. We promote networking by way of brown bag lunches, and a newsletter that goes to our Wisconsin agencies. These activities create better communication between the two groups.

In conclusion, nurses need to deal head-on with this question of practice issues. Ultimately, we have to ask if we do need the answer to all of our questions today. Can we answer them today? What will the half-life of such answers be? And should we really implement the answers today?

Susan Riesch:

"Why aren't advances in nursing research being implemented at the bedside?" We have heard three different responses and I hope to present still another response. In addition, I am going to tell you about two roles that I implement as an interim treatment for this problem.

The main reason that I think we are having some problems in implementing our research at the bedside is that of basic accountability. What is it that we are accountable for in our practice? According to the "Social Policy Statement" (American Nurses' Association, 1982) we are accountable for diagnosing and treating human responses to actual and potential health problems. We need more research to produce a taxonomy for those problems. Also we need more research to demonstrate the effectiveness of nursing treatments and thus the reimbursement for treatment that we think is necessary for our patients problems. The practicing nurse may not share this view as he or she is struggling with clinical problems day in and day out

At the University of Wisconsin-Milwaukee we are lucky enough to have not only a Center for Nursing Research, but also, a Nursing Center, which is a nurse-managed clinic. There are several other schools here who have clinics like this; for example, Purdue and Marquette Universities.

We define a nurse-managed clinic as an arena in which students can learn to practice and observe research implementation in clinical practice. This learning may include conducting research or applying research findings. In other words, it is a place where the nurses can implement the practice, do all the assessments and treatments and research. The goal when this nurse-managed clinic began, was that all the interventions and treatments implemented, would be based on theory or research. That was difficult to attain, as you can imagine.

The first problem was finding interventions that were truly research-based. We had two faculty members who, on the basis of their own research, wanted to test some nursing interventions. One researcher had studied childrens' responses to parents' divorce. She then devised some treatments to promote the appropriate responses or decrease the inappropriate responses in the children.

She offered this program three times before it was successful. Currently, the program is well supportive by the community. She is going to be adding to the literature soon and continues to test her therapies.

Another example is a study of spouse communication when one partner has a chronic illness. A nurse researched the topic couples' communication and chronic illness, determined how to treat the responses, and wanted to test the treatment in the community. We advertise for subjects and many referrals for people to take part in the treatment. People, however, weren't able to pay what she anticipated so we arranged third-party payment through physician referrals and billing. As a result, she is called a therapist rather than a nurse. The problem of reimbursement is closely tied with the use of research findings in practice.

Another advantage is that in the nurse clinic, the turf belongs to nurses. Patient and client access is nurse-controlled. People who come to us expect our students to work with them, they expect us to duct our research, and they expect nursing care.

Also, when we want to try out our results and implement our research, we are accountable to our peers, not administrators in other professions. We have a peer review system and a Human Subjects' Committee, but patient or subject access is nurse-controlled.

The other role which seeks to bring research and practice together is that of clinical nurse researcher. I have a joint appointment and spend 10 percent of my time at Mount Sinai Medical Center. Accountability for research and practice in this setting increased because the nurse researcher cannot promote lofty ideas or theories. The staff nurses are constantly making me realize what will or will not work in practice and they are the ones whose ideas and problems dictate the research to be done.

I spend four hours a week at the Medical Center where I consult, teach, meet with staff, critique studies and manuscripts, and provide a whole lot of encouragement. It has really been a pleasure because there is a lot going on in the system, and I do enjoy the role.

The chief activity is getting reported results to the staff, especially in terms of literature. The staff do not always know what has been done, but they have definite opinions about where we should be going. Also, the Center for Nursing Research provides support for these activities in terms of computer and data analysis support.

In the future, it is a goal that these nurses will have a climate in which they can initiate and implement their own research and apply the findings of others; and in which there will be a research committee or a group of persons to assist them in their work. Until this happens I will continue to be visible so that research continues to be trusted and will be something upon which we can base our practice.

In the future I hope to seek some funding and release time for nurses who really are interested in this area. What I would like most, however, is to see the institution adopt the philosophy that nurses are responsible not only for providing high quality family-centered nursing care to their patients, but also for providing student-learning activities at all levels. In addition, the nurses should be initiating, participating, and implementing research to improve their practice.

Questions to Dr. Riesch:

I would like to know where nursing stands today in regard to the issue of research that is not clinically-based.

Response:

I suggest that there is a place for what some people would call clinical research, for evaluation research, and for non-clinical research. We need to better define clinical research. Is it research that takes place in the clinical setting or is it research that tells us how to conduct clinical practice?

We need to build a body of theoretical knowledge that guides practice. I believe that research tests theories, and those theories need to be useful in nursing. They ought not to be so far from the reality of our clinical practice that we cannot see a use for them.

We are in a time when nurses must demonstrate that we do some things that matter in the actual delivery of health care. I would not suggest that clinical research is better than any other type of research. I think in the long run, the investigators who have a program of theoretical research will make the historically contributions. We must maintain a group of scholars whose work, although not immediately applicable may lead us to the next step in knowledge generation.

Additional Response:

I think there must be at least 40 definitions of clinical research. As a profession, we historically have had difficulty with definitions.

In terms of alienating groups, I have been struck by the enormous personal commitment and interest in my work with agencies in engaging them in the research enterprise. However, a great deal of fear and anxiety, apprehension about skills, and apprehension about being looked down upon are more problematic than the real issue of whether or not someone is interested in research. There's no question that they are. Those are the people I've worked with in this community.

Rather than trying to create a multitude of solutions, we have collectively pooled our resources and developed new models of cooperation. Hospitals should not be expected to copy our Center to figure out how to replicate sample hospital populations. It is the assumption of disagreement that is a problem for me. I think that there is a great deal of openness in our profession right now.

Additional Response:

I heard the question differently, and I see that there is still a great deal of value in research with regard to educational administration, nursing service administration, history, philosophy, and not just clinically-based research, however, it may be defined.

Question:

I have a comment and a question regarding research utilization. I would like for some of the panel members to share their experiences in working with staff in terms of utilization. I would like to hear more discussion of how utilization takes place and what has worked. We know that the politics are very diferent in different settings and communities. Also, I would like to hear some comments on the politics of research utilization.

Response from Dr. Riesch:

I can give you an example of an experience that I had in relation to politics. In one instance of utilization, in the Primary Care Clinic, there are many hypertensive patients, and the Clinic nurses wanted to use Swain and Steckel's 1981 study of adherence to contracts.

We looked at different kinds of things we could use as reinforcers for the contracts. Nurses in the clinic were very excited about using that information, and the physicians in that area also have been excited with the results of that study.

The main political problem we have run into has been more with specific units not wishing to give us access to clients for research. This has not occurred on the staff level, but has occurred with schools of nursing trying to get their students in for data collection on certain units. They say that their patients are overstudied or that there are going to be budget and staff cuts so they will not have time for this. That has been a real problem. This has not come from nursing.

Swain, Mary Ann, and Steckel, Susan B., Influencing Adherence among hypertensives. Research in Nursing and Health, 4, (1), March 1981, 213-222.

Basically, what I have done is avoid personal confrontation as much as I can and work through administration to open the doors in that area. A couple of studies that were reported in through nursing grand rounds were very well received and did have some impact on care. We need to do more "grand rounds-like" activities.

Comment by Dr. Downs:

I would like to comment on premature popularization of research findings. I have worried a great deal about some of those "cool" ideas when I can't see the data base. Now, very often readers are referred to the original article. I am not so sure how many of them obtain it. In fact, your comments gave me a terrific idea. How would you feel if Nursing Research published one of those empirical-type articles and had a companion piece with it that was a popular discussion of that study along with the interpretation of the data, etc? Not really a critique, but in more of an interpretive mode.

Comment by Dr. Loomis

I would like that very much. I would like to see it tried just to raise the question whether we need to take a clean position on the various scientific presentations of our research and argue for utilization literature as a critical need.

Response from Dr. Kirchhoff:

In the American Association of Critical Care Nurses' Research Committee we pulled together abstracts and research relevant to critical care nursing or research, and published a compilation of research abstracts in or around 1978. In 1979 we did not evaluate them, but just pooled them so that the abstracts were available. If the study interested the person receiving it, they could go back and read the original New England Journal of Medicine article, for example.

A second thing that the group has done is publish a newsletter called Focus. There was one article in it on all the studies done on catheterization of the left main stem bronchus for suctioning, and how that was best facilitated by turning the head. We listed all of the different nursing maneuvers that we have used in order to correctly suction a patient, and went through the studies with a very nice critique.

Question:

Every discussion I have heard around the country, would support your idea of at least taking a stab at it. One format that we used in Michigan and in the Michigan Nurse was to run a regular column presenting a research abstract. What it really did, however, was explain the study in every day English, and sometimes present discussion about how this fit into a larger body of knowledge. I hope that people know that Harriett Werley and Joyce Fitzpatrick are editing a series entitled, Annual Review of Nursing Research. It will be similar to the annual reviews that are done in some other professions, like psychology and sociology. That may meet some of the needs for research synthesis that we are talking about.

I have a third comment in response to the question about the politics in research utilization, when the handbook is available, you might be interested in looking at that - the one that Jo Horsley and the rest of the research utilization staff of the CURN Project are putting out. They walk people through the research process, to critically evaluate the research literature. It is a change process just like any other organizational change process. One of the steps that they advocate has to do with setting up a clinical trial which is done by making the innovation an empirical question. You challenge people from a questioning kind of position. "I don't know if this is going to work at our hospital or not, but are you willing to set it up and get some before-and-after data to see if it has been effective on at least one unit?" This is not really research, but rather clinical trial in getting some data about a particular innovation--a fundamental type of study that may warm the nurses up to further studies.

Caucus Group Reports

Participants were asked to:

1) identify common problems

2) Report current work that has potential for solving patient care problems through nursing research

3) Establish specific research-related objectives that MAIN as a facilitator could address to solve identified patient care problems

Report from the Illinois Caucus Group

Our group came up with four major areas which they believe contribute to the lack of applicability of research at the bedside. Let me preface my comments by saying that the first issue we dealt with is that the "bedside" is too narrow a term to describe what constitutes clinical practice. In particular, the people working in the community and settings outside of tertiary care institutions felt that "bedside" communicated something too narrow, so we chose to expand that concept. We really didn't come up with a new word, but "bedside" needs expansion.

The first problem was the problem of legitimacy. There is a lack of acceptance of the role of research in nursing practice because both intradisciplinary and interdisciplinary areas do not understand that research is needed in nursing.

Along with this is the problem of the lack of rewards given for conducting research and implementing research findings in nursing.

The second problem had to do with the lack of a critical mass of people within nursing, not only to do research, but also with the commitment to be able to present findings in a useful way for implementation in clinical practice.

The third problem had to do with the lack of networking about what is being researched and what resources are available to do research.

The fourth area relates to the lack of a model or models to organize information and guide nurses to questions that can be researched. Not only a model to guide the formulation of questions, but also to present appropriate models to direct the implementation of research at the bedside.

We have three recommendations for MAIN. First, MAIN should undertake some activities for the publication of data on what is being researched and also, the resources that are available to assist people in getting research started.

The second recommendation, which actually precedes the first, is the actual formation of a data base that nurses could tap into when they have identified specific, researchable questions.

Our third recommendation is that MAIN explore some strategies to communicate not only within the nursing profession, but also to the public-at-large, about what is happening in nursing. We feel that there is a dearth of information available to society on what contributions nursing is making in the area of research.

Report from the South Dakota and Wisconsin Group
(Group One)

One of the major problems identified by this group was that staff nurses don't view implementation of research to be a part of their daily job. It is related to how they are evaluated; they don't view themselves as being evaluated on their ability to do research, so they don't value it in the same way others above them do.

Also, there are so many educational levels among the practicing nurses that they aren't all equally able to read the research articles, interpret the research, and implement findings.

The time factor--nurses are so busy--was also mentioned.

Service institutions state that they would appreciate some mechanisms for having one or two exciting experiences occur within their agency that would set a positive feeling among staff members for trying implementation.

Another problem described was that of motivating the professional nurse, either as an individual or as a group, to either update or upgrade patient care through the use of policy or procedure committees. Too many nurses refuse to be bothered, don't go to meetings, or don't participate.

Also, absence of research role models in some of the more isolated communities was described as a rather major problem, but even within the community they could identify a possible research role model.

Another problem identified was the lack of experience and expertise in recognizing good research in educational agencies and institutions that would be worth replicating or implementing. Most would like some help with this.

Some ways in which MAIN could help us include:

1) Develop some kind of system for sharing human resources that would serve as the role models.

2) Provide a continuing consultant service.

3) Help us to state a hypothesis that would serve as a core around which to implement research.

4) Help us to identify clinical methodologies that would work.

5) Serve as a clearing house for an exchange between agencies. There should be regional sharing of effective ideas to help foster good clinical research in nursing.

6) MAIN should also serve as a clearing house that would help identify good studies that have been done that should be replicated in other areas within the MAIN geography. MAIN should be much more directive in saying that this was a good study, and that it should be tried in your area.

7) Serve as the source of information about data bases that are available, CONFER, and MAINlines.

8) Continue to hold research conferences that make research persons more visible to us and give us examples of good research.

9) Provide some kind of a computerized list of sources and ongoing research that has not been or may not be published, but is taking place in nursing.

Report from Michigan, Minnesota, and Missouri Groups:

The problems we identified are similar to those that have been discussed by the other two groups, particularly, the conflict between the researchers and clinical staff.

We also talked a lot about media/staff conflicts, and also as it relates to legitimacy and lack of reward for staff participating in research. We spent quite a bit of time in coming up with recommendations on what agencies can do. I do not know that many of them are exceptionally innovative, but we would like to share them with you anyway.

We really stressed the importance of joint appointments to set up researchers in the clinical setting (even if that is for only a very short period of time) to act as a resource to staff within that setting. The other helpful thing that some of the members within the group have already identified is that service staff should go into the educational setting. We always think of a joint appointment as an educator moving into the service area. There also may be some exchange of service into the educational setting in order to advise them on some ongoing research and methodologies.

The idea that service identify projects and negotiate those projects for completion as part of needed research projects in their institution came up, particularly in dealing with master's students. Some institutions have tried to institute a research commitee composed of either their internal people who review and approve the studies and look at the application to their own facilities, or have research committees composed of the researchers, educators, and service people who critique proposals.

There was encouragement to work more with nursing service agencies to develop appropriate methodologies. There was some real concern about the methodologies that were being proposed by some of the researchers. Also, we encourage regular informal meetings with representatives from service research and the educators to talk about what could be done together in order to decrease some of the barriers and ill feelings. We would like to hold both researchers and students more accountable to share information. We feel that there are a lot of clinical studies being done in service for which we never know the outcomes because they are not shared within the clinical setting. Getting the information has been difficult for some people in service.

I think one of the most important things we mentioned was that the researcher should acknowledge the service setting and staff for the data collection that is actually done there. Often researchers do not do that.

What can MAIN do? The other two groups have talked about the data base. We also recommend that when that data base is put together, whether that is the synthesis of literature findings or a list of abstracts, studies, title of studies, replication of studies, or what needs to be done, - that somehow we work with the other regional agencies in trying to share the information in more than just a regional capacity.

Our other concern or recommendation would be that mentors should be identified, particularly for facilities that are not associated with or in proximity to academic centers so that these resources could be made available to them.

Report from Wisconsin and South Dakota (Group Two):

Our group discussion started off with a positive statement that this conference did not spend a lot of time talking about the politics, polarized issues, or who is the enemy. I think that this could probably be a recommendation that we should not look for "the enemy", but find how we can work together more productively.

Some of the issues that we talked about are replications from some of the other groups, but I am just going to go through them quickly: Issues regarding reimbursement for doing research in a clinical agency, release time: who will be the role model for doing research and practice, the difficulties on the issue of communicating to researchers, especially in regard to students and maybe to the clinicians in the agencies; and the difficulties before they even write up the proposal for doing research in the clinical agencies were all mentioned.

Also, another issue is that there are not enough resources for nurses in rural areas. Most of the resources are centered in large urban areas.

Another issue is that there is not enough expertise to go around, especially in educational settings. Students come in expecting to do research in just about every area, and if you look at other disciplines, students go to those programs with the idea that they are going to be doing research under some particular type of faculty, who has some expertise.

We looked at some of the recommendations as "futuristic." The things that MAIN can do are: identify centers of expertise and excellence where students or clinicians can go to receive help, look at collaborative models between state nursing associations and state nursing agencies; they could spend more time critiquing studies: and possibly sponsoring poster sessions or conferences on how to critique instruments.

MAIN needs to encourage nurses and students to use CONFER, the computerized system of nursing research support, as a way of developing a data base for nursing problems.

MAIN could speak to the issue of the importance of replicating studies. Some of the individual agency recommendations asked how research in the future will be funded, especially since federal funding is decreasing. Special interest groups also could generate money for their special interests, hold a conference, and generate some research money.

Agencies could have research conference days and have more collaboration between agencies and nursing societies for putting on these conferences.

Finally, there was a recommendation that agencies need to realize there are more benefits than just the results of the research. Someone mentioned some of the benefits that they have received participating in research with Carol Lindeman, and that they were not only producing results with research, but also staff job satisfaction. Nurses were stimulated by innovations in other areas of the hospital as a result of that research.

Report from the Indiana, Iowa, and Kansas Group:

We identified several outstanding issues. One of them relates to application of research and what to do with it in small hospitals that don't have a clinical specialist. In fact, the directors of nursing service themselves may not be skilled in advanced research methodologies.

Another issue related to research findings in settings other than acute care, when most situations talked about today related to acute care settings rather than examples of community health and long term care facilities.

Also important is an issue related to textbooks; we need to have textbooks in educational processes that relate to more than just the "whats" of practice and include the "whys" and research findings on a more routine and regular basis than they do right now.

The other topics that we talked about are similar to the other groups with some of the same recommendations. First, in relation to the agency, they can establish a long-range plan for integration of research findings into service and nursing practice, provide stimulating reading of all kinds for staff nurses, and provide faculty to enrich their teaching via integration of the research findings in the classroom. They also can have available persons to assist in the research processes that can be carried out locally and in the intepretation and utilization of research findings.

The establishment of a local nursing research committee was mentioned as having potential for agencies that don't have such a committee. Also information is needed for staff nurses regarding research. This includes educational programs, communication links between service and education, and a climate that encourages both faculty and practitioners to think integratively about research, service, and education.

Sharing relevant research questions of practitioners with the educators who are going to be precepting students or doing research of their own was a major recommendation. The establishment of reward systems for staff nurses and others in the facility, who do get involved either with the implementation/utilization of research findings or replicating findings, is important. In terms of MAIN's assistance in integrating research, there were three main areas identified with several portions to each one.

First, with regard to publications or dealing with publishers to get the results into the right journals, MAIN should summarize the findings of various research studies in MAINlines and provide resource people to assist in identifying what is available in the research. That probably was a recommendation that related mostly to other kinds of settings other than acute care. Regional networking could be done through MAIN for other settings, such as long-term care facilities as well as for acute care, and synthesizing the literature. These all relate to publications.

Several agencies in the MAIN network could do that and be coordinated through MAIN, but MAIN in its coordinating efforts could identify or fortify the areas having the greatest need of research in the opinions of the membership. This would facilitate sharing where replication is needed. There could be an identification of the studies that needed the replication most quickly so that those could get done.

The third area in which MAIN could help relates to facilitating education. This was mentioned as needed at the local amd regionals levels, with more poster presentations, etc., and the consultation services.

Report from the Nebraska, North Dakota, Ohio, and Oklahoma Group:

Our number one issue was agencies wanting evaluative research. Research in education and agencies requires more grounded research. There is a need to establish public relations with service agencies prior to implementing research and a need to find well designed research that can be generalized before being replicated. Agencies would prefer to study literature and implement what appears to work, and then, if it works, continue without the rigor of research. Textbooks and nursing care need to cite nursing research to support recommended interventions.

Also, each agency needs input from health care agencies that are implementing research. If the agency would employ more clinical nurse specialists it would generate enthusiasm for nursing research. Research should be modeled by graduate students for agencies.

One suggestion was to establish journals clubs among staff nurses to do literature searches on specific problems, and generate enthusiasm for research applications in practice.

Education should assume a leadership role in supporting and implementing research. We should try to form relationships with others and replicate and/or search the research literature as a basis for designing policies and procedures.

The agency, particularly the top administration, must support and give high priority to research. We must assist the staff in publishing and this doesn't necessarily mean publishing only research, but also publishing clinical articles. This requires a search of the literature and encourages nurses to become more involved with research. Also, quality assurance in agencies tends to lead directly to research.

We also should ask service agencies to identify problems they would like researched. Every institution should publicize its philosophy of nursing; science, and application of research as a source of scientific findings. That way, you would get a committment. In addition, agencies should give recognition to those who conduct research.

For MAIN, it would mean:

bringing together agencies and practical research solutions to provide for broader replication;

formalizing the process and procedures for cooperative research;

developing a grant proposal for consultants to promote implementation of research findings in nursing, especially in the non-university attached agencies;

coordinating data collection of replications in numerous care agencies; and

providing a column in the newsletter inviting agencies who implement research to publish their experience.

Poster Presentation Abstracts

Midwest Alliance in Nursing proudly presents these posters which are the work of forty-five nursing leaders and express the dedication that these men and women have toward improving patient care in the Midwest.

Representing years of hard work and experience, the posters are a catalyst for yet more ideas and innovations to improve the nursing profession.

The three posters rated highest by the judges on the following criteria received awards from the Midwest Alliance in Nursing, giving recognition to the importance of nurses' contributions to patient care and to the education of nurses.

Emphasizing areas of nursing specialization, the posters were judged on the basis of the following criteria:

(1) Importance/Significance/Validity of the idea for improving patient care or nursing education outcomes

(2) Originality

(3) Practicality

(4) Care in developing and testing the innovation

(5) Degree of improvement the innovation offers to nursing care of patients, or to the education of nurses

(6) Degree to which the idea has been adopted in a practice or educational setting

JUDGES

Florence S. Downs, EdD, FAAN
Judith A. Floyd, MSN
Karin Kirchhoff, PhD
Phyllis B. Kritek, PhD
Maxine E. Loomis, PhD, FAAN
Susan K. Reisch, Doctoral Candidate

CLIMATE AND OSTEOARTHRITIS: A RETROSPECTIVE STUDY

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Joyce M. Laborde, Ph.D., R.N.
Associate Professor

Agency(ies): College of Nursing, University of North Dakota
Grand Forks, ND 58202 Telephone: (701)777 -4508
Title of Poster: Climate and Osteoarthritis: A Retrospective Study
Abstract: (Must be typed within margins of the box below)

A retrospective study using data from the National Weather Service was performed to examine the effects of weather upon reported joint symptoms in 160 osteoarthritics from four different settings. Osteoarthritic symptoms were determined by self-reports of pain, stiffness, mobility problems and perceived levels of pain-related stress. These measures were obtained via initial and follow-up interviews.

Simple regression analysis demonstrated an overall significant relationship ($R = .33$, $P < .05$) between climatic temperature (79° to 20°F) and reports of arthritic symptoms for the total study group. Weather change (decreasing barometric pressure with concomitant humidity rise) was significantly related to pain intensity (r .24, $P < .01$); pain duration (r -.04, $P < .05$) and increased indoor mobility problems (r -.04, $P < .05$) for 53 subjects. Additional findings showed that 12 persons living in a rural environment reported significant increases in pain, stiffness, and pain-related stress (R .62, $P < .05$) when weather change occurred.

COGNITIVE STRESS REDUCTION INTERVENTIONS FROM ADJUSTMENT THEORY

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Joan L. Stehle, R.N., M.S.N., Doctoral Candidate (Also Lecturer, University of Wisconsin-Eau Claire School of Nursing)

Agency(ies): **Indiana University School of Nursing**

Telephone: (715) 834-4330

Title of Poster: **Cognitive Stress Reduction Interventions from Adjustment Theory**

Abstract: (Must be typed within margins of the box below)

A proposition from the French, Rodgers and Cobb theory of adjustment (1974) served as the basis for development of cognitive stress reduction interventions for nurses dealing with persons experiencing occupational stress. The theory explains how work stress (defined as lack of fit between subjective or objective person demands and environmental supplies or between environmental demands and person supplies) is related to psychological and somatic strain. The theory further describes how the worker is motivated to cope with stress through four methods.

The method chosen from the theory for the basis of stress reduction strategies was the subjective cognitive coping method. The proposition utilized was that subjective person-environment misfit will become less discrepant through increased accuracy of perception of the environment or the self, resulting in a reduction of psychological and/or somatic strain. It was believed that the nurse could play an important part as a significant facilitator in the worker's motivation for the move from defensive distortion to more realistic perceptions of self and/or environment. Improvement in perceptual accuracy, then, was the focus of the strategies developed. The cognitive reorganization principles of Ellis (1973) and Burns (1980) were modified and applied to perceptual distortions expressed by workers experiencing person-environment misfit.

A pilot study was conducted to test the efficacy of the interventions. The subject population consisted of 31 adult volunteers employed by a large long term care institution. Subjects were first given the Person Environment Fit Survey, a tool designed to measure presence of occupational stress along nine dimensions, and the Hopkins Symptom Check List (Derogatis et al., 1974), a tool designed to measure strain along four dimensions. Twelve of the 31 volunteers then participated in four stress reduction sessions apiece, held individually. Session one focused on the principles of cognitive-perceptual distortion reduction. Session two focused on perceptions of greatest work stresses and stress reduction. Session three focused on the distortions regarding low self esteem. Session four focused on the distortions present with anger. Following sessions the entire group of 31 was again given the questionnaires.

Results showed a significantly greater decrease in overall occupational stress for the session participants than for the control group. More specifically, the experimental group experienced significantly greater stress reduction in: 1) rewards of the job, 2) organizational participation, 3) underutilization, and 4) qualitative overload. The differences in individual strain following sessions were not as pronounced. However, the experimental group did show significantly greater decreases in somatization and anxiety following the interventions.

Although the intervention strategies designed do require testing with larger samples, the results suggest that these cognitive-perceptual stress reduction techniques could be fruitfully employed by nurses, especially in the areas of occupational health and mental health consultation. The results also suggest that theory based interventions can be beneficial for nursing practice.

COLLECTION FACTORS INVOLVED IN REPEAT URINE CULTURES

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Frances Fischbach, Asst. Professor .M.S.N.
University of Wisconsin-Milwaukee

Agency(ies): Assisted by Janice Heinemann - Nurse epidemiologist
Family Hospital Telephone: (414) 963-4801
Title of Poster: Collection Factors involved in Repeat Urine cultures
Abstract: (Must be typed within margins of the box below)

The purpose of this study which is in progress, is to examine the factors that may influence the repeating of a urine culture due to failure to isolate a causative organism in significant titer. It is designed to determine if there is a difference in the collection and examination procedures between urine cultures that have to be repeated and those that do not. An investigator developed questionnaire is to be completed by both the person collecting the specimen and by the person examining the culture. The questionnaire items are divided into three categories of information: patient; collection; and laboratory.

This exploratory study is based on a preliminary study, (Phase I). In Phase I, laboratory records of a 210 bed hospital were examined for 3 months. It was determined that, out of 200 urine cultures, 60 had to be repeated. Interestingly, none of the repeat urine cultures involved males and very rarely did a urine culture require repetition in maternity patients.

The anticipated outcome of Phase II of this study is the analysis and use of data to aid in improving techniques of obtaining specimens for culture. Improved skills in collection procedures could influence and prevent delays in diagnosis and infection control practices, and promote cost effectiveness and quality assurance. Implementation of results of this study will enable nurses to better understand the protocols of diagnostic tests, to better prepare and educate their clients for examinations, and to more skillfully collect specimen and carry out various testing procedures.

COMMUNICATION, A MAJOR PARAMETER IN PAIN CONTROL

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

(Duplicate copies of this page as needed for individual poster presentations)

Name (s) (if jointly presented) and title (s):
Barbara Kellerstrass, R.N., M.S., Primary Nurse II, Oncology Unit
Mary Murphy, AD, R.N., Primary Nurse II, Oncology Unit
Patricia A. Martin, R.N., M.S., Nurse Researcher

Agency (ies): Miami Valley Hospital
Dayton, Ohio 45409

Title of Poster: Communication, A Major Parameter in the Pain Control for the Terminal Oncology Patient: Initial and Longitudinal Pain Assessment Tools

Abstract: (Must be typed within margins)

Pain is an individual affair with subjective interpretation based on the individual's experience, cultural, and behavioral systems. Health professionals' interpretation of patient's pain is also subjective and related to their own experience, culture, and value systems. In addition, "cancer" conjures up all the subjective responses to the disease. Currently, cancer pain management follows a very haphazard route. About 50 to 80% of all terminal cancer patients experience severe, uncontrolled pain. Literature indicates that preconceptions, inadequate knowledge, and the lack of a systematic assessment method by physicians and nurses contribute to inadequate pain control. Improved pain management through communication was an outgrowth of a research project to delineate pain manifestations and establish management protocols.

The initial assessment uses the "Pain Assessment Guide," an adaptation of the McGill Pain Questionnaire. This questionnaire provides information concerning pain quality and quantity. Physical and mental coping mechanisms are delineated by the patient. The modified McGill Questionnaire retains the scoreable word descriptors on the subjective sensory, affective, and evaluative aspects of pain. These assessments outline areas for individualizing the nursing care plan.

Longitudinal data are collected using a flow sheet. The flow sheet utilizes a present pain intensity scale with a 1-10 intensity rating. The data represent a quantitative index of pain that measures improvement as a result of pharmacological and/or non-invasive methods of control. The "Pain Flow Sheet" is maintained until the patient reports a rating of 3 on the pain rating index.

The combination of the use of these two assessment tools and the resultant increased dialogue from the inservice necessary to initiate the study provides a common vocabulary for nurse, pharmacist, and physician. The plenariness of the proposal brought favorable, reinforcing recognition from peers and physician/pharmacist colleagues, superimposing the "scientist-scholar" image on that of "clinical practitioner." The most important result has been a shortened time frame for achieving effective pain management in individual patients.

A DEMONSTRATION PROJECT TO ASSESS ASSIGNMENT METHODS TO IMPROVE THE QUALITY OF NURSING CARE

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s): Edward Halloran, R.N.,Ph.D., Senior Vice President for Nursing (U.H.O.C.); Marylou Kiley, R.N.,Ph.D., Associate to the Senior Vice President for Nursing (U.H.O.C.); Evelyn Lutz, R.N., Ph.D., Associate Professor of Nursing (C.W.R.U.)

Agency(ies): University Hospitals of Cleveland, Case Western Reserve University

Telephone: (216) 368 - 2180

Title of Poster: A Demonstration Project to Assess Assignment Methods to Improve the Quality of Nursing Care

Abstract: (Must be typed within margins of the box below)

This demonstration project explores a solution to a long-standing problem in nursing. Differing levels of experience and education among nursing personnel can produce communication and collaboration problems and thus adversely affect nursing services afforded patients. Matching patients with varying requirements for nursing care with nurses with varying capacity to meet requirements is the single option available to fully utilize the different capabilities of heterogeneously prepared nursing staff. Most studies of nursing activity assignment have considered task and time orientation to nursing functions. These studies have given little attention to the critical determinant of the complexity of care, the patient. The management of the broad spectrum of educational experiential backgrounds is an important issue because collaboration among nursing personnel is critical for cost effective nursing care. A good deal of emphasis in the literature has been placed on the capacity of nurses to communicate well with other health practitioners; yet, there has been little attention paid to collaboration among nurses.

The purpose of the project is to examine four approaches to the assignment of delivery of nursing care. We expect that nursing unit staff can be purposefully managed to increase collaboration and communication and to optimally utilize nurses with differing backgrounds. Quality nursing care is operationally defined as the extent to which nursing staff members work together on a patient's care to produce nursing services that are highly integrated, continuous, and coordinated. Four nursng divisions will be used, each with a different management mode with respect to nurse patient assignments. The evaluation design will be quasi-experimental with before-after comparisons for each division. The measures include assignment patterns, patient characteristics, nursing resources, organizational support and unit cost data.

It is anticipated that the outcome of this project would be of value to nursing services throughout the country. The presentation of the planned project at Poster session might stimulate similar studies in other settings thus enlarging the data base for drawing conclusions about assignment methods to improve the quality of nursing care.

THE DOCTOR OF NURSING PROGRAM: AN EMERGING IDEA FOR IMPROVING NURSING PRACTICE

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s): Jannetta MacPhail, R.N.,Ph.D., Dean and Professor of Nursing (C.W.R.U.); Administrative Associate in Nursing (U.H.O.C.) Edward Halloran, R.N.,Ph.D., Senior Vice President for Nursing (U.H.O.C.); Associate Professor of Nursing (C.W.R.U.)

Agency(ies): Case Western Reserve University and University Hospitals of Cleveland **Telephone:** (216)368 - 2544

Title of Poster: The Doctor of Nursing Program: An Emerging Idea for Improving Nursing Practice

Abstract: (Must be typed within margins of the box below)

In 1973 our faculty began an extensive examination of nursing, nursing education, health care, and society within the context of what could be projected about the future at that time. The deliberations culminated in 1975 with the acceptance of the Doctor of Nursing concept as the basic preparation for entering professional nursing practice as a generalist. From 1975 to 1978 the idea of implementing such a program was tested within the university, Ohio and within the nursing profession. The curriculum was developed over a five year period. The first class was admitted in 1979 and will be graduated in May 1982.

The program is designed for persons who have experienced a liberalizing education prior to being admitted. The sequence, rigor and scientific base of study is comparable to the educational preparation of professionals in other practice disciplines such as dentistry, law and medicine. The development of the program is based on the assumption that well prepared nurses who are generalists and who have a command of the cognitive, interpersonal and technical skills required in nursing practice are essential to the improvement of nursing care. Nursing continues to have a shortage of truly professional generalists and M.S.N. and Ph.D. prepared nurses. These latter nurses who are prepared at graduate levels usually are required in other than practice positions.

The collaboration endeavor between the School of Nursing and University Hospitals of Cleveland facilitated the development and implementation of the Doctor of Nursing program. Nurses with advanced degrees who hold clinical faculty positions are active collaborators with regular faculty in all of the school's educational programs.

The graduate of this program will be expected to 1) be an initiator in seeking opportunities to engage in nursing care; 2) bring a wealth of knowledge to the deliberative process as a basis for identifying the need for and selection of the most cogent nursing strategies; 3) carry out these strategies efficiently, effectively and with interpersonal finesse when assisting clients in their efforts toward seeking optimal health; 4) use their repertoire of knowledge and skill to describe, explain and validate their nursing practice; 5) facilitate or develop new and emerging roles of the professional nurse and 6) participate in the development of new approaches for health care delivery.

An extensive evaluation project is being planned to examine the impact of the graduate in clinical environments.

The presentation of the scope, nature and goals of this educational program at this particular poster session could be of value to our nurse colleagues in the midwest since some of our forthcoming graduates may apply for positions at health care institutions or for graduate study at universities in this region.

THE EFFECT OF USING A SPECIFIC PATIENT CARE PLAN ON NURSES AND PATIENTS

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Dorothy Matthew, R.N., M.N., Instructor

Agency(ies): Department of Nursing, Wichita State University
Telephone: (316) 689 - 3610

Title of Poster: The ST. PA Patient Self-Care System

Abstract: (Must be typed within margins of the box below)

The Effect of Using a Specific Patient Care Plan on Nurses and Patients

The purpose of this study was to devise and test a tool which would meet accepted criteria for recording nursing process. Using theoretical frameworks from decision-making, Orem's Self-Care and nursing process, a tool was planned which allowed the nurse to logically record the nursing process, reflecting the process and product of nursing assessment and diagnosis.

The ST. PA Patient Self-Care System consists of two forms used dependently. The Health Data Sheet reflects categories of self-care, the basis of nursing assessment. Identified deficits justify the need for nursing and are stated as nursing diagnoses on the Patient-Nurse Care Plan. This plan provides a continuous record of patient progress toward goals appropriate for each diagnosis. Both forms are intended to be part of the permanent patient record. The tool is precise concise, complete and clinically functional. Use of the ST. PA system fulfills the requirements of JCAH Standard IV for Nursing Services. This standard states that "individualized goal-directed nursing care shall be provided to patients through the use of the nursing process".

The ST. PA Patient Self-Care System was used on a 22 bed medical-surgical unit in a 200 bed acute care hospital. Research RN's were instructed prior to the six-weeks research period. Data were collected from satisfaction surveys (patients and RN's), from nursing care plans and from the Watson-Glaser Critical Thinking Appraisal.

Significant findings were limited to the nursing records survey which indicated that nurses using the ST. PA system recorded significantly more nursing diagnoses, goals and plans than they recorded on the hospital care plan. No quality assessment was made. Eleven RNs used the ST. PA system with 94 patients. The five RNs who used the system more than five times showed a tendency towards improved Watson-Glaser scores. An additional finding was 137 notations, pertinent to patient care, which were found in the ST. PA records of 66 patients, but not found elsewhere in the nursing records.

The ST. PA Patient Self-Care System provides a permanent part of the patient's record which accurately reflects the contribution of nursing towards planning and implementing nursing care to achieve desirable health goals.

Informed consent was obtained from all participants, and the right to privacy of nursing records was maintained. This research was partially funded by the Office of Research and Sponsored Programs, Wichita State University, Wichita, ansas.

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

(Duplicate copies of this page as needed for individual poster presentations)

Name (s) (if jointly presented) and title (s): McElmurry, B.J., Associate Professor, U of Illinois College of Nursing; Egan, E.C., Associate Professor, U of Minnesota School of Nursing; Jameson, H. Director of Patient Care Services,

Agency (ies): Rochester Methodist Hospital, Rochester, MN.

Title of Poster: Evaluating Nursing Research Climates in Hospitals: A Feasibility Model

Abstract: (Must be typed within margins)

Presents a format for assessing the research climate in an acute care setting. The format was implemented in one institution as a means for answering the question, is it feasible to initiate a systematic studies program in a given practice setting? The components identified as essential conditions for a research climate include: subject participants, market factors, organizational system, economic factors, legal/statutory provisions, facilities and resources, and contributions to the research endeavors of educational institutions. A report of the process experiences associated with implementation of this format has been published. The poster session will be used to share the format as well as the structured interview guide and questionnaire developed by the investigators. The structured interviews were conducted with two groups of hospital personnel: (1) The management staff, and (2) hospital administrators and other department heads. The questionnaire obtained information from the registered nurses employed by the hospital and covered four areas: (1) The research needs and interests of the nurses; (2) The nurse's experience with systematic study activities; (3) The nurse's perception of the climate within the hospital for the conduct of nursing studies; and (4) The nurse's identification of support services needed to conduct clinical studies and to realize the application of findings in providing patient care. The results and conclusions from one application of this format will not be presented as it would be a breach of trust to report detailed findings for an agency which contracted with the investigators for the conduct of the study.

EVALUATION OF THE BACCALAUREATE NURSING CURRICULUM AT UW-M

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Dorothy D. Petrowski, R.N., Ph.D., Assoc. Prof. & Chairperson of
The Baccalaureate Evaluation Task Force* (*listed on poster)

Agency(ies): University of Wisconsin-Milwaukee School of Nursing
Telephone: (414) 963-5587

Title of Poster: Evaluation of the Baccalaureate Nursing Curriculum at UWM

Abstract: (Must be typed within margins of the box below)

EVALUATION OF THE BACCALAUREATE NURSING CURRICULUM AT UWM

There is no touchstone or standard definition for curricular evaluation. The evaluation of this 124-credit baccalaureate is essentially synonymous with a comparison between program objectives and performance indicators. This research study is based on data collected about the first two graduating classes (i.e. 1980) from the new curriculum.

The theoretical framework which guided the evaluation study was the CSE model, developed and used at the UCLA Center for the Study of Evaluation, hence the letters CSE. The same model or conceptual framework has been used at all developmental stages of the 124-credit curriculum. The evaluation design used is a quasi experimental one, the Interrupted Time-Series Design.

The sample includes students, alumni, faculty and agency personnel who work with students. Questionnaires, with mostly structured questions, were used to collect data, and a computer program was set up to monitor student entry-exit data. Cronbach's coefficient alpha established the internal consistency of instruments.

Analysis of data included frequencies, correlations, correlation-regression analysis, and coding of open-ended responses. The analysis revealed that students perceived most program objectives were met to a high degree, and working independently and developing technical skills were cited as the most valuable experiences. Faculty appreciated the diverse areas of expertise of colleagues, and agency personnel commented on the excellent theoretical background of students and their proficiency in problem solving.

FRAMEWORK FOR THE INTERPRETATION AND DELINEATION OF PARAMETERS FOR DECISION MAKING WITHIN NURSING PRACTICE AND EDUCATION

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):

Laurel Nelson, B.A., R.N.

Renee Larson, M.S., R.N.

Agency(ies): University of North Dakota College of Nursing

Box 177, University Station, Grand Forks, SD 58202 Telephone: (701) 777-4173

Title of Poster: See below

Abstract: (Must be typed within margins of the box below)

Framework for the Interpretation and Delineation of Parameters for Decision Making Within Nursing Practice and Education

This idea depicts the modes available to the nurse and client in the achievement of a client's optimal health. The framework visualizes two primary components of the nurse-client relationship.

The first component is the determination of the client's present health status. The second component involves determining the most appropriate mode of nursing strategy. The modes identified are restoration, maintenance, and promotion. The methodology used is the nursing process.

Assumptions necessary for the interpretation of this framework include the following: 1) Health is the congruence of perception, adaptation, and function, 2) A fundamental internal energy is inherent in all individuals as a result of the dynamic interaction of an individual's bio-psycho-social process, 3) Internal energy tends to draw perception, adaptation, and function into congruence, 4) External energy sources are sometimes necessary to augment the individual's internal energy in order to achieve optimal health, 5) Nursing practice exists as an external energy source to be used in a dynamic interaction between the client and nurse to accomplish the collaborative goal of optimal health, 6) Dynamic interaction occurs within the client's health potential (capacity for optimal health) as influenced by the client's bio-psycho-social processes and his environment.

This conceptualization can be utilized in the discipline of nursing and serve to improve nursing care by interpreting and delineating the parameters within which decision-making must occur to achieve the client's optimal health. This delineation will assist in providing a more responsible and effective use of nursing.

The practical implications of this framework are two-fold:

for nursing education -- it provides an understandable delineation and visualization of basic nursing concepts.

for nursing service -- it provides an applicable guide for nursing strategies.

GRAFFITI METHOD OF DEVELOPMENT OF NURSING STANDARDS

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s): Diana L. Frankfurth, R.N., M.S.N., Lecturere University of Wisconsin SON
600 Highland Ave., Madison, Wisconsin 53792

Agency(ies): University of Wisconsin; Bethesda Memorial Hospital
Boynton Beach, Florida

Telephone: (608) 263-5185

Title of Poster: "Graffiti Method of Development of Nursing Standards"

Abstract: (Must be typed within margins of the box below)

A methodology in writing nursing care standards obtaining maximum staff nurse participation in their construction was developed, field tested and initiated at Bethesda Memorial Hospital, Boynton Beach, Florida during 1978-1980. An orthopedic unit was chosen as the field test unit. A theoretical framework, to unify the outcome and process entries, was chosen from Claire Campbell's Nursing Diagnosis and Intervention in Practice. The diagnostic categories of comfort (we further subdivided this into physical and emotional subcategories), hygiene, assistance, prevention, education and safety are the integrating strands of the standards. We then identified the most frequently occuring orthopedic populations on that unit as those of: hip trauma, traction, trauma to the extremities, amputation and spinal cord injury.

The terms standards, outcomes and process were defined in everyday language. The definitions and instructions were placed on shelf paper with the orthopedic patient group across the top and the diagnostic categories down the side. The papers were hung in the nurse's station and charting room, where all of the nurses for all of the shifts had free access to them. The nurses had inservice instruction in what was expected from them. This "graffiti" method allowed them to write down what they saw as key components of what they were doing as they were doing it, as well as eliminating the need for extra-duty time or interruptions in their patient care. They contributed individually and collectively through small group discussions. It was hoped at the onset, that their participation in the construction process would make later evaluation through the quality assurance Grand Round mechanism more acceptable, and that's what happened.

At the end of three months the 5 papers were collected and collated by the clinical nurses specialist into a first draft. The staff nurses were again consulted and appropriate changes made. In the writing process it became evident that there would be duplication unless an outline format was used to allow easy cross referencing of material. Also developed were a set of general care standards and a Realms of Nursing Care Assessment Guide that further clarified the final documents and eliminated duplication. The system was later initiated on all nursing units in that hospital.

IT'S UP TO ME: HYPERTENSION EDUCATION THROUGH GROUP PROCESS

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

(Duplicate copies of this page as needed for individual poster presentations)

Name (s) (if jointly presented) and title (s): MB

Mary Beth Riner, R.N., B.S.N., Coordinator of Nursing Development of Chronic Disease

Agency (ies): KS Department of Health & Environment, Bureau of Community Health Services, Chronic Disease Program, Forbes Field, Bldg 730, Topeka, KS 66620

Title of Poster: It's Up To Me: Hypertension Education through Group Process

Abstract: (Must be typed within margins)

Kansas hypertension screening efforts have shown an increase in aware, uncontrolled hypertension since 1972. The current mode of treatment is medication therapy and general client education about the disease. Our hypothesis is that clients need more than knowledge and medication; they need support to make the necessary lifestyle changes for hypertension control. We provide this knowledge and assistance in the form of small support group classes, entitled, "It's Up to Me", led by a specially-trained nurse facilitator. Each class session consists of blood pressure and weight checks, an informational slide-tape presentation, a relaxation or hand warming exercise, and a group interaction activity. A client-nurse contract allows for individualized client care and promotes the concept of self-responsibility for health. The entire program consists of six 1-1/2 hour sessions covering each of the following topics: hypertension, stress, medications, nutrition lifestyle changes and decision making. Our pilot sample population consisted of 96 participants from one urban and two rural areas in Kansas. During the time period of the support group classes, the mean systolic blood pressures were lowered 13mm Hg. and the mean diastolic blood pressures were lowered 4mm Hg. In the year since the pilot study, clients have shown an increase in knowledge about hypertension, compliance with medication regimen, and attainment of blood pressure goal. Long-term client follow-up is in progress.

Over ninty community health nurses throughout our state have received education for implementing this program. A Pre-Workshop Competency Packet is sent to each nurse who pre-registers for the workshop to update the nurses' knowledge of hypertension in a format acceptable to adult learning. A fifteen contact hour workshop is provided for groups of nurses desiring to be prepared to offer the group education program to clients. The focus is to develop group process skills of the nurse to prepare her in facilitating chronic disease education support groups. The style of leadership is given attention in order to help the nurse become aware of her own style and the need to adapt it to the variety of situations encountered.

LIVING FEMALE: A SIMULATION

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Virginia Newbern, R.N., Ph.D., Professor of Nursing
Winifred Walter, R.N., M.S.N., Supervisor

Agency(ies): College of Nursing, The University of Akron, Akron, Akron, Ohio 44325
Visiting Nurse Service of Greater Cleveland Telephone: (216) 375-7554
Title of Poster: Living Female: A Simulation 3300 Chester Avenue, Cleveland, OH 44414
Abstract: Must be typed within margins of the box (below)

The game, Living Female: A Simulation, was developed to help students, by the use of simulation, to: (1) identify antecedents and consequents of choices made across the life cycle of females; (2) adopt an ecological perspective in assessing female clients; (3) synthesize learning regarding females across the life cycle; (4) apply this learning in our nursing practice; (5) model this learning for peers and students. The game spans the life cycle by developmental stages. Players make choices at intervals through each stage which impact on events/choices at the next interval, with the object being to use their learning to make the best choices for health and well-being. Critical content of the game is derived from the developmental and situational crisis literature and normal human development. It was piloted on an interdisciplinary group, men and women, Spring, 1981 and used as a synthesis/evaluation tool for an intensive graduate credit course, The Health of Women, Summer, 1981. Living Female: A Simulation is a practical tool, readily replicable, to enhance nursing practice with female clients by providing practitioners with a holistic, ecological perspective for assessing and meeting the needs of female clients and a soundly based rationale for involving those clients in decision-making.

A MODEL FOR A NURSING INTERNSHIP PROGRAM

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Catherine A. Andrews R.N. Inservice Instructor (Staff Development Department)

Agency(ies): Mercy Hospital; Janesville, Wisconsin 53545
1000 Mineral Point Telephone: (608) 756-6686

Title of Poster: A Model for a Nursing Internship Program

Abstract: (Must be typed within margins of the box below)

This model addresses the needs of the new graduate nurse as s/he enters practic in the acute care setting. The model was constructed following a thorough review of the literature and following interviews of thirty recent graduates in three hospitals in southern Wisconsin. Specific concerns and "we'd like" were incorporated into the design. The new graduate must be recognized as a clinician with beginning clinical skills whose strengths must be accentuated and weaknesses diminished in a supportive environment.

This model incorporates three components: the clinical, the cognitive, and the supportive. The majority of time is spent in the clinical component. The neophyte nurse works closely with a preceptor, who has been selected by the coordinator of the nurse internship, on the assigned unit. The preceptor must meet certain criteria such as being clinically adept, able to maintain a full time (or comparable) schedule, have excellent communication skills, etc. Mutual and individualized goals are made by the preceptor and intern at bi-weekly meetings and appropriate learning experiences are selected. A sense of self-confidence and self-satisfaction must be maintained as additions in responsibility are made.

The cognitive component includes approximately one day (8 hrs.) of classroom content. Information identified as necessary for the neophyte nurse might include such topics as intershift communications, setting priorities, management of emergency situations, to name a few. A variety of teaching techniques must be used, including self-study and observations in supportive departments as desired by the individual nurse.

The supportive component is two-fold. The new graduate must be made to feel significant and worthwhile to the unit by her peers. In addition weekly meetings with other new graduates can foster a sense of unity and cohesiveness as each shares individual problems, concerns and seeks input from those in similar situations. The threat of isolation is eradicated and self-esteem maintained.

This structure is but a skeleton. The author maintaines that the design and its utilizations must be flexible. Interns must be challenged, yet be allowed to develop in a supportive environment. This educative, protective experience meets these criteria.

NORMAL NEWBORN CHARACTERISTICS

Name (s) (if jointly presented) and title (s): Mrs. Vicki Kokotkiewicz R.N.

Agency (ies): Marion County Health Dept., Bureau of Public Health Nursing
1435 Shelby Street
Indianapolis, IN 46203

Title of Poster: NORMAL NEWBORN CHARACTERISTICS

Abstract: (Must be typed within margins)

Nose: *
1. may sneeze often to clear nose, doesn't mean he has a cold

Ears: *
1. can hear from birth

Head: *
1. is larger than body
2. has soft spot on top of head

Neck: *
1. is weak, needs support when picking up

Activity:
1. very individual
2. he may sleep most of the time or be awake quite a bit
3. while sleeping may make strange noises and move occasionally
4. he is not coordinated

Eyes: *
1. can see object 12-18 in. from face
2. color may change
3. may look cross eyed at times
4. has no tears

Hands: *
1. fists often clenched and arms flexed
2. hands may be blue due to immature circulation
3. fingernails are thin and sharp

(FORM OF NEWBORN IS HERE)

Trunk: *
1. barrel shaped, soft
2. cord is soft, glossy and moist the first day then dries and becomes hard and dark (2 weeks time)

Digestion:
1. spitting up is common, so are hiccoughs
2. may lose weight in first few days, will regain birth weight in a week

Skin:
1. immature oil glands may cause tiny white bumps on face
2. dry and peeling skin is common

Genitals: *
1. may seem large in relation to body
2. newly circumcised penis looks irritated

Stools:
1. first stools are tarry and black, then change to brownish green and then to yellowish gold
2. may have stool after each feeding

Feet and Legs: *
1. legs are often flexed
2. feet may appear blue due to immature circulation

*A line is drawn to connect the characteristic with the newborn.

NURSE EXTERNSHIP: A BLENDING OF EDUCATION AND SERVICE

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

(Duplicate copies of this page as needed for individual poster presentations)

Name (s) (If jointly presented) and title (s):

Nancy Swank, R.N., BSN, Education Coordinator
Ella Penewit, R.N., Education Coordinator

Agency (ies): Miami Valley Hospital, Dayton, Ohio 45409

Title of Poster: NURSE EXTERNSHIP: A BLENDING OF EDUCATION AND SERVICE.

Abstract: (Must be typed within margins)

The concept of a nurse externship program is a practical innovation much needed in nursing today. The goal of all nurse externship programs is to facilitate the transition from nursing student to graduate nurse. Nursing Education and Nursing Service must collaborate to minimize the usual stress and anxiety that the new graduate experiences in the hospital environment. At Miami Valley Hospital the Department of Nursing Continuing Education designed such a program incorporating the primary nursing modality for baccalaureate nursing students who had completed their junior year.

Extensive groundwork was necessary to insure program success. Hospital management was consulted early in the process to insure that the program's goals and objectives meshed with corporate goals and objectives. Several meetings between the BSN program's faculty and the hospital's Continuing Education Coordinators were required. Evaluation research was an integral part of insuring accurate program evaluation of this endeavor. Primary Nurses were chosen as individual preceptors. They and their Clinical Nursing Coordinators attended pre and post program seminars to develop skills as mentors and direct supervisors. Values clarification and principles of adult learning were two major components of these seminars.

Eight persons were chosen to participate in the ten-week summer program. Formal classes were held to acquaint them with the hospital's policies and procedures. Classroom content on adult learning principals and method of self growth were included. Each nurse extern was assigned to a preceptor on a specific medical/surgical unit and worked with this nurse in the clinical setting following the nurse's schedule and patient assignment schedule. The extern, with the preceptor and Continuing Education Coordinator, established realistic weekly goals and proceeded at an individualized pace in assuming nursing responsibilities. There were also weekly seminars designed to help the nurse externs integrate their knowledge into practice as well as gain new knowledge regarding the role of the professional nurse in an acute care setting.

The evaluation by externs, preceptors, Clinical Nursing Coordinators, and Continuing Education Coordinators was overwhelmingly positive. Their impression was that this program provided opportunities for self growth and promoted application of theoretical principles in the clinical setting . They also felt that participation in the program would enhance the externs' senior year and would shorten orientation time for them as new graduates. Upon completion of the program each nurse extern indicated the desire to seek employment at this institution upon graduation. An expanded program is scheduled for the summer of 1982. The model used to develop this program included planned evaluation research. This model has broad application to many practice settings.

NURSING CENTER FOR FAMILY HEALTH

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Jo A. Brooks, Associate Professor of Nursing
Mary Lou Holle, Assistant Professor of Nursing

Agency(ies): School of Nursing, Purdue University
West Lafayette, Indiana 47906 Telephone: (317) 494-6341
Title of Poster: Nursing Center for Family Health
Abstract: (Must be typed within margins of the box below)

The Nursing Center for Family Health (NCFH) was designed to enrich the curriculum for the baccaleaurate degree nursing students at Purdue University. It expands the scope of primary health care experiences available to students, involves students in an expanded nursing role in a non-traditional setting and provides them with nurse role models in primary care. Initial funding was from a Special Projects - Curricular Improvement Grant from Division of Nursing, Public Health Service and provided funds for remodeling of space within the School of Nursing, purchase of equipment and supplies, and faculty salaries.

The NCFH opened October 19, 1981 and is staffed by the co-directors and senior students from the Community Health course and the Leadership and Management course. In the first semester the NCFH was opened, the students planned and implemented a sickle cell screening program, hypertension and diabetes screening programs, and provided counseling and referral to walk-in clients. There were approximately 450 client contacts during the 2 month period.

Plans for the Spring semester, 1982, included involvement with the Association of Women Students Health Awareness Month, we will offer a "Pap Clinic". Continuation of hypertension and diabetes screening and monitoring, and complete health histories and physicial assessments will be available through the NCFH.

Two faculty members will be offering programs through the NCFH. One is a weight control program to begin January 25 and the second, a stress reduction workshop, will be in March. The co-directors are developing case loads and in this way function as role models for students.

NURSING CONSULTATION: IMPROVED PATIENT CARE AND INCREASED PROFESSIONAL SATISFACTION

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

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Name (s) (if jointly presented) and title (s):
Bonnie Allbaugh, R.N., M.S.N. - C.N.S.
Mary Zwygart-Stauffacher, R.N., M.S.N. - C.N.S.
Representing Clinical Nurse Specialist Group at:

Agency (ies):
Methodist Hospital
309 West Washington Avenue
Madison, Wisconsin 53703

Title of Poster: NURSING CONSULTATION = IMPROVED PATIENT CARE AND INCREASED PROFESSIONAL SATISFACTION

Abstract: (Must be typed within margins)

A model of nursing consultation is being formalized at Methodist Hospital in Madison, Wisconsin. The concept developed when the organizational structure changed the Clinical Nurse Specialist from an administrative line position to a staff position. This allowed the C.N.S.'s to move from a unit-based attainance to a patient-population-based focus and increased their availability.

After review of the literature, a modified consultation model was selected. The modification from "pure" consultation highlights the responsibilities of the consultant to also case-find" and make available expertise known. A list of the available specific consulting areas in patient care management and professional development was established.

The nurse consultant is defined as a clinical nurse specialist, nurse practitioner or nurse with advanced education and/or experience. The consultee is any nurse or health professional who identifies the need and initiates the request for consultation. The process of consultation is a temporary, voluntary, collegial relationship between the consultant and consultee based on the consultee's perceived need for assistance. This may involve a need for an expert, a resource, or a process facilitator. Upon request for consultation, contracting between the consultant and consultee is done verbally. Emphasis is placed on the freedom and responsibility of the consultee as the implementer and final decision maker, therefore enhancing their professional practice.

The model has great potential for improved patient care and professional satisfaction by providing more efficient problem solving through greater availability of a nursing "expert".

- increasing development of nurses' problem solving skills through knowledge acquired in the consultation process.
- increasing professional satisfaction of the nurse consultant from appropriate use of acquired knowledge and skills.
- increasing satisfaction in consultee's (staff nurse) practice through readily available clinical resources.
- enhancing abilities in identifying nursing problems.
- providing a mechanism for implementation of nursing diagnosis by assisting in identifying nursing problems.
- improving documentation by clarification of problems.
- increasing accountability and responsibility through individual practitioner decision to use a clinical resource.
- enhancing formal and informal educational channels by problem identification.
- improving communication between and among nurses.

NURSING PRACTICE STRUCTURE: A MODEL FOR STAFF SELF-GOVERNANCE

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

(Duplicate copies of this page as needed for individual poster presentations)

Name (s) (if jointly presented) and title (s):

Marlys Peterson, R.N., M.S., Vice-President Nursing
David Allen, R.N., Ph.D.,

Agency (ies): Methodist Hospital
309 West Washington Avenue
Madison, Wisconsin 53703

Title of Poster: NURSING PRACTICE STRUCTURE: A MODEL FOR STAFF SELF-GOVERNANCE.

Abstract: (Must be typed within margins)

The toll on nurses of the conflict between bureaucratic organizations and professional values has been the focus of considerable discussion in recent years. The high cost of turnover to institutions has also been well documented. Nurses have frequently cited "working conditions" and "too much time spent on non-nursing tasks" as contributing to their dissatisfaction. Furthermore, a number of people have suggested that a bureaucratic work structure tends to reinforce routine task performance and penalize initiative and autonomy.

Our study sets up and evaluates a model for nursing governance that is designed to return clinical decision-making power and responsibility to the level of the RN-controlled unit. By decentralizing decisions over patient care to the unit level, policies and procedures can be more responsive to the needs of the unit's specific patient population and more congruent with the values and abilities of the RN staff. A Nursing Council comprised of elected representatives from each unit functions as a forum for coordinating institution-wide issues and advising Nursing Administration. It assures staff-level participation in all areas affecting patient care.

The design is essentially a pretest and repeated post-test measure with a non-random comparison group drawn from a similar hospital in the same community. A pilot project involving the Nursing Council and three (3) volunteer units is now underway. Intensive survey and feedback information will be used to guide further implementation with other units. Stratified random samples will be post-tested at six-month intervals for two (2) years.

The instrument is a compilation of several validated tools which have been designed to measure such variables as job satisfaction, perceived and actural participation in decision-making, individual growth need strengths, professionalism, job and organizational commitment, job involvement and several others. Data on cost-effectiveness and turnover will also be gathered.

NURSING RESEARCH HOLDS THE KEY TO IMPROVED NURSING PRACTICE AND EDUCATION

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Roberta Chwalek, R.N., M.S.N., Assistant Director of Nursing (Practice Emphasis)
Mary Beth Petersen, R.N., M.S.N., Director of Hospital Education (Education Emphasis)

Agency(ies): St. Michael Hospital, 2400 West Villard Avenue, Milwaukee, WI 53209
Telephone: (414) 263 - 8000

Title of Poster:

Abstract: (Must be typed within margins of the box below)

Nursing research holds the key to improved nursing practice and education. Nursing research is the vehicle by which an investigator's suspicions about the art of nursing becomes a scientifically based intervention.

The challenge is two-fold; one part is, communicating these innovations and interventions to others in the nursing profession (the challenge of dissemination of nursing research to impact practice). The second part is developing the critical thinking and methodological skills of practicing nurses.

At St. Michael Hospital our answer to this challenge is the Research Development Committee. Functions of the Research Development Committee include;

1. assisting collegial development in research skills,
2. facilitating use or availability of research findings,
3. critiquing studies,
4. coordinating research ideas,
5. developing socialization into research within hospital and within the community, and
6. reviewing articles relevant to practice.

The group is composed of masters prepared nurses/graduate students, and a doctorally prepared nurse consultant from the University of Wisconsin - Milwaukee. We believe that the Research Development Committee provides for development of research skills, and dissemination of the information that nurses need for improved and innovative nursing practice.

The poster itself will list over fourteen specific activities of the committee which accomplish these functions. Examples of some of these activities include; coordination of data collection for a hospital-wide evaluation study, publication of "Research Corner" in the Notable for Nursing Newsletter, presentations by nurse researchers from other agencies, distribution of an annotated bibliography of relevant research for monthly nursing grand rounds, and the presentation of an educational series in the research process.

PRIMARY NURSES MAKE HOME VISITS TO POST PARTUM MOTHERS

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

(Duplicate copies of this page as needed for individual poster presentations)

Name (s) (if jointly presented) and title (s): Gloria Long, R.N., Vice President - Nursing
Nancy Endress, R.N., Pediatric Clinical Specialist

Agency (ies): Carle Foundation Hospital
611 W. Park St.
Urbana, Illinois 61801

Title of Poster: Primary Nurses Make Home Visits To Post Partum Mothers

Abstract: (Must be typed within margins)

Consistant with our philosophy of family centered care, primary nurses make a post partum home visit to families within ten days of the birth of their infant. Primarily primiparas and high risk families are visited but every mother is given the opportunity to have a home visit with their primary nurse. The purpose of the home visit is discussed with the family and scheduled prior to the mother's discharge from the hospital.

During the home visit the wellness of both the mother and the infant is assessed by the nurse. This includes a physical assessment, observations regarding bonding, satisfaction with new roles and reintegration of the family system. Reinforcement of self care and infant care taught in the hospital occurs as needed. Positive feed back and reassurance are used liberally. Appropriate referrals are initiated. These have included immediate referrals to a physician for a sick infant as well as public health nurse follow-up for continuing support and guidance for the family. The nurse clarifies with each family their plan for future health care for the infant and themselves.

Prior to making home visits nurses attend a seminar which includes maternal/infant assessment and care, the process of making home visits and family assessment. After completing the seminar the nurse observes a home visit and then makes two supervised visits before she goes out on her own.

The post partum home visit program has been well received by families and has helped them be more competent and confident in caring for their new infants. The nurses involved have found the experience challenging and rewarding which has increased their job satisfaction. Overall it has been a effective program for the families and nurses involved.

PRIMARY PREVENTION FOR REALITY SHOCK

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s): 1. Toni Stevenson, Quality Assurance Director for Nursing 2. Pat Lambert, Nursing Program Director 3. Carol Franck, Director for the Undergraduate Program

Agency(ies): 1. Ingham Medical Center 2. Lansing Community College 3. College of Nursing, Michigan State University **Telephone:** (517) 355 -6523 (C. Franck)

Title of Poster: Primary Prevention for Reality Shock

Abstract: (Must be typed within margins of the box below; E. Lansing, MI 48224

At the initiation of the nursing administration unit of an acute care hospital, and with the collaboration of the faculties of both a local baccalaureate and associate degree nursing program, a two level employment opportunity for nursing students has been established to reduce the reality shock usually experienced by new graduates.

A bi-level process has been designed whereby the students will initially be introduced to routine unit operations, the rudiments of patient care, and the various roles of nursing personnel, thereby providing them with an opportunity for organizational skill development and diversity of experience in a non-threatening role. At the second level the student's role would be expanded to include more advanced patient care activities and documentation. During this second phase they will increase their technical and procedural skills.

The participating agencies are developing a system designed to share human and media resources so that nursing students/employees can learn and demonstrate competency in basic skills at a most convenient time and location and that such demonstration will satisfy both educational and service needs. Undergraduate students will be provided with employment opportunities which will incorporate and strengthen the practice skills and clinical judgment most commonly found wanting in recent nursing graduates. Consequently, one anticipates that recruitment and retention of new nursing graduates into acute care settings will subsequently be enhanced.

Key practices of this project include:
1. Opportunities for students/employees to demonstrate adequate performance of selected nursing skills at either the educational or service agency.
2. The use of common or comparable media in all three agencies.
3. The development and common use of checklists representing the most up-to-date practice.
4. Collaboration of educators responsible for the teaching of basic skills in all three agencies in the development of these common modules.

Future plans: The acute care agency currently initiating this project is one of four such agencies in the community. As the program continues to be refined, other agencies will be encouraged to establish comparable employment programs using and building on the developed modular base.

THE RELATIONSHIP BETWEEN SEX ROLE IDENTITY AND DEPRESSION IN NURSES

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

POSTER PRESENTATION APPLICATION FORM - *Submit by Feb. 12, 1982

Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s): Ann K Jacobson
Ann K. Jacobson, R.N., M.S.N., Instructor

Agency(ies): University of Wisconsin-Milwaukee School of Nursing
Milwaukee, WI 53201 Telephone:(414)963 -5145

Title of Poster: The Relationship between Sex Role Identity and Depression in Nurses

Abstract: (Must be typed within margins of the box below)

This study addressed the following question: What is the relationship between sex role identity and depression in nurses? It posited that nurses tend to be high in feminine traits and attitudes which will be correlated with depressive symptoms. The registered nurses employed at a 350 bed metropolitan hospital in Milwaukee, Wisconsin were surveyed to test this question. According to the conceptual framework of this research, female socialization is a process in which females assimilate into their own identity 1) society's belief that women have less value and lower social status than males, and 2) society's expectations for acceptable behaviors which women can demonstrate. It was argued that this socialization process plays a significant role in the development of feminine personality characteristics. These feminine traits and behaviors can be conceptualized as having both sex role and depression components. A traditional feminine sex role identity supports selection and socialization into traditional female occupations, such as nursing. The female nurse also experiences unique professional stressors which are related to the historical and educational tradition of nursing. Finally, it was argued that female socialization promotes the development of depressive behaviors, such as dependency, helplessness and an orientation toward others. In addition, specific life experiences and stressors unique to women may have psychological impact which may be reported as depressive symptoms. Interaction between sex role and depression components of feminine personality is demonstrated in the nurse that expresses traditional feminine traits and attitudes and depressive symptoms. A questionnaire was used to collect the data. There were 301 registered nurses employed at the hospital, 208 completed questionnaires, however, 203 were usable creating a sample n = 203. Analysis of the findings did not support the hypothesized relationship between feminine traitedness and depressive symptoms. However, the findings did support a statistically significant relationship between traditional attitudes to feminine sex roles and depressive symptoms. Data analysis also indicated statistically significant relationships between both androgynous traits, masculine traits and lack of depressive symptoms. In addition, findings indicated that career/self orientation to feminine sex roles was not associated with depressive symptoms. This exploratory study supports the assertion that a relationship exists between sex role identity and depression. Limitations in scope and sampling procedures are discussed as are significance to nursing, practice and research.

SELF-CARE AGENCY AND PROBLEM-SOLVING SKILLS OF MOTHERS

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

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Name(s) (if jointly presented) and title(s):
Jill C. Skinner, R.N. Graduate Student University of Wisconsin-Madison.
School of Nursing H6-290 53792

Agency(ies): Funded by investigator
Telephone: (608) 836-5966 (Home)
Telephone: (608) 263-6974 (Office)

Title of Poster: Self-Care Agency and Problem-Solving Skills of Mothers Regarding Well-Child Health Care

Abstract: (Must be typed within margins of the box below)

Problem: Throughout the review of literature on self-care, clients and self-care agency, and research on self-care very little has been done concerning characteristics of clients that do well in a self-care regimen. Dorothea Orem in her book, Nursing: Concepts of Practice, 2nd Ed. makes several assumptions concerning the characteristics of those clients with a high level of self-care agency; one of which is stated on p. 40: "Self-care action is practical in orientation. Performing a self-care measure involves a decision, a choice." Orem assumes those clients carrying out self-care have the ability to make judgments regarding their health problems. This assumption has not been studied. The purpose of this study is to evaluate such an assumption.

Subjects: Subjects will be recruited from the clinic population of the Family Practice Clinic-U of W, who have delivered babies in the two weeks prior to the beginning of this study.

Design: This is a descriptive study aimed at identifying the presence or absence of a correlation between problem-solving skills and self-care agency. Mary Jean Denyes' tool to measure self-care agency, Denyes Self-Care Agency Assessment Questionnaire, will be given to those clients consenting to participate in the study. Following this, clients will be interviewed using the Pridham et al Problem-Solving Tool, "How I Deal with Problems Regarding Care of My Baby." Scores will also be recorded. Results of the self-care agency tool and problem-solving interview will be coded. Correlational statistics (r-coefficient with T-test for group comparison, one-way analysis of variance, and analysis of covariance) will be run to determine any significant correlation. Statistical consultation will be obtained. After coding, results of tools and interviews will be destroyed. Data analysis will be done, and the findings will be reported.

Location of Study: The study will take place in the subject's home.

The proposal for this research has been approved by the Human Subjects Committee as of September 28, 1981, protocol number 81-692-204. The Research Committee for the Department of Family Medicine and Practice have given their support and approval for this study. The study will begin in the second week of October, 1981.

STRESS AND ONSET OF PARKINSON'S

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Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Dolaine Genthe - Associate Professor

Frances Fischbach - Assistant Professor

Agency(ies): University of Wisconsin-Milwaukee

Medical College of Wisconsin Telephone:(414)963 -4801

Title of Poster: Stress and Onset of Parkinson's

Abstract: (Must be typed within margins of the box below)

This exploratory descriptive study was designed to investigate the perceptions of Parkinson patients about the magnitude of stressful life change event experienced prior to onset of Parkinson's disease and about their early symptoms of the disease, prior to medical diagnosis. Two questions were posed for examination: 1) Do persons with Parkinson's disease experience an increased frequency and magnitude of life change events prior to onset of disease? 2) Do persons with Parkinson's experience a number of puzzling early symptoms prior to diagnosis?

Sixteen out of twenty-two subjects, eight men and eight women, responded to a mailed two part questionnaire: The first portion of the questionnaire was the Schedule of Recent Events (SRE) which is composed of forty-three forced choice statements constructed to identify the number of times specific life change events had been experienced by the subjects. The second part of the questionnaire was an investigator developed tool that was composed of fifteen questions constructed to identify early onset symptoms experienced by the subjects prior to medical diagnosis.

All of these subjects with Parkinson's disease did experience high life change units prior to onset of disease, and, many early symptoms were reported, such as occurrence of painful cramps and swellings in the lower extremities, chest pain, and unpleasant burning and cold sensations in the head and hands.

Many of the implications and recommendations of this study are directed to the American and National Parkinson Foundation. Implications for nursing education and practice include the need for students and practitioners to be aware of role stress plays in determining the state of health and/or illness, the need for health professionals to be aware of the early puzzling symptoms of the disorder so that they are able to guide persons to seek help, diagnosis, and treatment, and the need for clinicians and learners alike to use life change evaluation as an intervention in the supportive management of care in some patients.

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Name (s) (if jointly presented) and title (s):

Barbara O'Brien, R.N., B.S.N., M.S.
Instructor, Department of Nursing

Agency (ies): Southwest Missouri State University
901 S. National
Springfield, Mo 65804

Title of Poster: A Teaching Method To Stimulate Creative Group Problem Solving

Abstract: (Must be typed within margins)

Nurses across the nation are confronted with multiple, complex problems that call for innovative, creative resolution. In the past, nurses have been socialized as dependent, passive health care providers who avoided risk taking and failed to fully develop their creative potential. This suggests that educational programs need to emphasize a variety of knowledges and skills required for effective decision making. If developed in professional schools and nourished in practice settings, creativity could become a common characteristic of nurses.

One such necessary skill is the use of a systematic problem solving process that stresses the value and usefulness of creativity in generating solutions to problems. Research shows that actively engaging in play-like activities increases creative productivity.

A teaching-learning game designed to improve nurses' problem solving abilities has been adapted for use in the BSN for RN program at Southwest Missouri State University. The objectives of this game are to stimulate creative thinking and to illustrate the advantages of group problem solving.

Students work in teams of three or four to complete an on-campus treasure hunt that involves solving a variety of puzzles. The puzzles require use of non-creative reasoning, logic and mathematical skills, but do stimulate use of creative skills such as synectics, lateral thinking, brainstorming and divergent thinking.

Each puzzle requires two steps: solving the puzzle and completing an action. The actions require movement from one academic building to another on the SMSU campus. The game concludes when the final puzzle is completed. The hunt is timed and students are penalized for arriving at incorrect answers. In order to promote competition and stimulate goal achievement, a prize is awarded for the team with the shortest completion time.

During the past three semesters this has proven to be an effective method of encouraging students to explore the merit of creative problem solving.

TOWARD MORE OBJECTIVE APPRAISAL OF MATERNITY AND GYNECOLOGICAL PATIENTS

MIDWEST ALLIANCE IN NURSING

3rd Annual Program Meeting, April 1-2, 1982

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Please duplicate as many copies of this page as needed for individual Poster application.

Name(s) (if jointly presented) and title(s):
Evelyn M. Lutz, R.N., Ph.D; Associate Professor of Nursing (C.W.R.U.);
Associate in Nursing (U.H.O.C.)

Agency(ies): Case Western Reserve University
University Hospitals of Cleveland   **Telephone:** (216) 368 - 2180

Title of Poster: Toward More Objective Appraisal of Maternity & Gynecological Patients

Abstract: (Must be typed within margins of the box below)

The need for nurses to be objective in their appraisal of patients is important. Nurses practicing on maternity or gynecological units, however, frequently use words such as small, minimal, moderate, large or profuse to describe the amount of drainage on perineal pads. The descriptive words used by one nurse often do not have the same meaning to another nurse who subsequently cares for the same patient. The written and oral communication of our descriptions of the amount of vaginal drainage, therefore, could result in a misinterpretation of the patient's condition.

Several years ago I began to explore this problem and raised the question as to whether nurses could learn to determine in cubic centimeters (c.c.'s) the amount of drainage on perineal pads. Through a series of controlled studies, I determined that nurses could learn to make an estimate of the amount of drainage within 5 cc's above and below the actual amount on pads which were saturated with known amounts of blood. The series of studies included the use of actual pads with known amounts and a subsequent development and testing of self-instructional slide-tape unit. A follow-up study revealed that nurses could learn from the slide-tape unit to determine the amount of drainage within + or - 5 cc's and transfer this learning into their daily practice.

The practice of estimating in cc's the amount of drainage on perineal pads has been in use at MacDonald House (maternity hospital of U.H.O.C.) for about nine years. Since its inception there, nurses who have left the setting have transferred the practice elsewhere and recently have encouraged me to share more widely the idea of estimating the amount of vaginal drainage in cc's and ways for learning this skill.

THE USE OF A COMPARATIVE METHOD FOR TEACHING NURSING RESEARCH

MIDWEST ALLIANCE IN NURSING - THIRD ANNUAL PROGRAM MEETING

Theme: Innovation and Invention: Ideas for Improved Nursing Practice and Education

Poster Presentation Application Form - *Submit by February 12, 1982

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Name (s) (if jointly presented) and title (s):

M. Joan Mallick, R.N., Ph.D., Assistant Professor of Nursing

Agency (ies): Cleveland State University, Baccalaureate Nursing Program
2344 Euclid Ave #31
Cleveland, Ohio 44115

Title of Poster: The Use of a Comparative Method for Teaching Nursing Research

Abstract: (Must be typed within margins)

A common teaching strategy in introductory research courses is to have students read excerpts of completed research which are illustrative of various portions of the research process (literature review, design, etc.). Unfortunately, these excerpts are usually isolated from the complete context of the research report and from other research reports. That is, only a portion of a research report will be used, and portions of several reports are seldom compared. The result for students are difficulties evaluating research reports in their totality and in determining strengths and weaknesses of various research studies vis a vis one another.

In an attempt to overcome the above-cited problems, a comparative approach was used. Four research articles, each dealing with the same topic (pain), were assigned as "core" articles in an introductory nursing research course. Each study had used a different research design and data analysis.

In addition to theoretical readings, students were required to read portions of each of the core articles as various portions of the research process were covered in class. For instance, when the conceptual framework of research studies was discussed, students were required to identify the conceptual framework for each of the core articles. During class discussion the strengths and weaknesses of each article were identified and compared. This assignment was repeated for course discussions of literature review, design, statistical analysis, and implications.

Advantages of this comparative method were that students were able to (1) evaluate a research report in its entirity, (2) evaluate a research project vis a vis other research projects dealing with the same topic, and (3) more easily recognize that research design is not a function of a research topic but of the research questions and some practical constraints of a research situation. Finally, students were more confident in performing a research critique since they had had guided experience in critiquing several research reports.

This teaching strategy may be conceptualized as using the research strategy of control. That is, by holding the topic of the research constant, students were better able to analyze the variability in research design and implementation.

THE USE OF BENSON'S RELAXATION TECHNIQUE IN PREPARING PATIENTS FOR CARDIAC CATHETERIZATION

Name (s) (if jointly presented) and title (s):

Marilyn Frenn RN, MSN
Dr. Richard Fehring RN, DNSc
Agency (ies): Marquette University - College of Nursing
3029 N. 49th
Milwuakee, Wis. 53210

Title of Poster: The Use of Benson's Relaxation Technique in Preparing Patients for Cardiac Catheterization

Abstract: (Must be typed within margins)

Reduction of stress associated with medical management of patients (e.g. intrusive examinations or use of extensive monitoring equipment) has been listed as a priority by the ANA Commission on Nursing Research. Nursing literature describes stress associated with cardiac catheterization due to the overwhelming amount of machinery, isolation, and concern about the procedure and the future. The number of catheterizations done in the U.S. has increased from 44,000 in 1965 to 189,000 in 1975. Thus an ever larger number of persons experience the stress of catheterization.

The use of Benson's relaxation technique was examined as a means of reducing stress responses associated with cardiac catheterization. Benson describes a "relaxation response" which is a hypometabolic state with physiological changes opposite to those experienced in generalized arousal. Elicitation of the relaxation response takes about 5 minutes to learn and has been shown to reduce indicators of stress such as blood pressure, heart and respiratory rate, and plasma norepinephrine levels.

Ten randomly assigned patients were taught Benson's relaxation technique before catheterization in addition to standard pre-catheterization teaching. Patients practiced the relaxation technique 3 times before catheterization and used it according to their own preference during the catheterization. Ten other consenting patients were randomly assigned to a control group and only received standard pre-catheterization teaching.

Baseline measurements of blood pressure, heart and respiratory rate and STAI A-State anxiety questionaires were recorded before teaching was begun. These measurements of stress response were again recorded just before, during (except respirations and A-State anxiety) and just after the catheterization. Group means were compared using T-tests.

Group means were not statistically different at the 0.05 probability level. However, lower stress responses were seen in the relaxation group on every variable measured. For example, relaxation group means were 9.3mm Hg lower systolically and 3.8mm Hg lower diastolically during catheterization.

Nurses routinely quantify physiological responses such as blood pressure, heart rate and respiration and assess psychological coping ability. Therefore staff and cardiac catheterization nurses could likely utilize and evaluate the use of this technique to reduce stress associated with catheterization. The lack of side effects associated with Benson's relaxation technique and the stress reduction trends demonstrated in this study favor such use until further research can be accomplished.

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